ALASKA HEALTH CARE COMMISSION

FRIDAY, JUNE 15, 2012

8:01 A.M.

FRONTIER BUILDING, ROOM 896

3601 "C" STREET

ANCHORAGE, ALASKA

VOLUME 2 OF 2

PAGES 241 THROUGH 408

P R O C E E D I N G S

7:59:49

(On record)

CHAIR HURLBURT: This morning, we want to focus on some of the technology, not the medical technology, but the communications information technology that is available and is coming available and that is being used to enhance access to health care, to enhance quality of health care, and we have several folks here with us from around the state.

The first session we're going to have is Use of Technology to Facilitate Access to Care with some examples. Alaska really was one of the very pioneer states, and Stewart will probably have some of that history, but back in the days of the earliest NASA satellites when there was some funding available to try some things, one of them was a part for us to use up here before it went on to India to do some things, but Alaska really has been in the forefront of a lot of this technology, partly because we're willing to try new things, partly because of the very unique challenges in the United States to deal with, such as scattered population over such a broad area with a relatively small population. And so we continue to have that engagement here.

On first panel, Dr. Stewart Ferguson, who is the Chief Information Officer for Alaska Native Tribal Health Consortium and the President of the American Telemedicine Association, I

think which reflects the recognition that, although there are not a whole of us up here in Alaska, Stewart's expertise and the importance of what he has been involved with, with the tribal health system there and around the state, has been recognized; and then Dr. John Kokesh, who is the Medical Director of Department of Otolaryngology at the Alaska Native Medical Center will be here to present, I think, more of a clinical aspect of it. So I'll turn it over to.....

COMMISSIONER ERICKSON: Can I just note a couple of things real quick before we get started?

CHAIR HURLBURT: Yeah.

COMMISSIONER ERICKSON: This is Deb. I wanted to mention, for folks on the phone, that the presentation that we'll be looking at in the room here is available on the Commission's website on our June 2012 meeting page, if you want to try to follow along.

And also just a note for the Commissioners. We have a really packed agenda this morning, but we're going to try to make some time at the end of the morning for you to just kind of reflect back, brainstorm. We'll capture, in bullets, some of your preliminary thoughts after the presentations this morning of things that you would want to capture for our 2012 report related findings on the use of telecommunications technology for improving access to care and also if you have any preliminary thoughts, ideas about what you might want to

start making recommendations to the Governor and the Legislature, specifically, about. So a real quick brainstorming we'll capture on some slides at the end of the morning this morning. So be thinking about that throughout the presentations this morning.

One more thing, too. We have kind of an overview. It's on our website. It's in your notebooks behind tab five, and folks in the room on the back table, an overview kind of description of the session this morning and our hopes and expectations for the different sets of presentations.

DR. FERGUSON: Well, thank you very much, Dr. Hurlburt. It's an honor to be here with the Alaska Health Care Commission, and thank you very much for the opportunity to focus on telehealth.

Alaska -- and I'm thrilled to be here with Dr. John Kokesh, and John and I have worked together for years. So we're going to share this presentation. We're going to focus on four areas today, really kind of to make the statement telehealth works. I think, for years, there has been a question, are patients happy, are providers, does it make a difference, and we're kind of past that point. Excuse me?

UNIDENTIFIED COMMISSIONER: (Indiscernible - away from mic)

DR. FERGUSON: Oh, I'm sorry. I apologize. And I guess I should say questions during the middle of this are totally

fine. We're really open to that. Then we'll talk about the business case and that's kind of where it's getting interesting, I think, because now we have enough data and we know how it works, but we should focus on how financially it works. Then we're going to talk a little bit about lessons learned from other programs throughout the world and a little bit about next steps and what we think might be possible that the Commission might want to focus on. Next slide.

So just to set the definitions of telemedicine/telehealth -- those words get confused. I am the President of the American Telemedicine Association. I really ought to be President of the American Telehealth Association, but it's the word that's just stuck in the lexicon of those that use it. Telemedicine was the word that was used maybe 20 years ago. It was medicine, and it was direct medical care over distance, hence the "tele" part. Telehealth has evolved to become kind of the larger concept. It's not just medical care. It's wellness. It's education. It's everything we do to deliver health care. I can tell you I don't care which word we use. I think we're all talking, and we kind of know what it feels and smells like. Next slide.

So again just to kind of lay out some of the words we're going to use today, there are really roughly three big branches of telehealth, and they're defined by the technology, and to some extent, by the care models.

We talk a lot in Alaska about what we call store and forward telemedicine. That's like email. We capture data, and we send it, and a provider can look at it. It's sometimes called asynchronous telemedicine or telehealth. Radiology is a perfect example. When you do radiology, you capture a study. You capture the images. You send it to somebody to look at it. Dermatology, images of skin, those are obvious examples.

Live videoconferencing or synchronous telehealth is where people are on a system at the same time, live video, live sound. It's used very heavily in behavioral health and telepsychiatry.

Remote monitoring is where, typically, you're monitoring a patient, often times, a chronically ill patient, congestive heart failure, things like that, where they are, often times, in their home, and they will monitor vital signs, weight, blood pressure, those kinds of things, and a reading center/monitoring center can watch that patient, so slightly different. That's a slide I say 1990-2002. Really, the world has become very blended since then, as you would expect with technology. So telepsychiatry has the store and forward component and a live video component. You can even have a remote monitoring component. So it's really kind of becoming an all-encompassing concept. Next slide.

So we use a lot of store and forward in Alaska, and we

may be the world's leader in the use of store and forward telemedicine. We started doing this in the 1990s because, frankly, we didn't have the bandwidth to support live video through our sites. We have 250 sites as part of our system, and there were less than ten that had broadband connections when we started. So we had to look for a solution that could work over phone lines. Well, now we have broadband, but we have found that we just have a lot of efficiencies from this model of telehealth. We send images, obviously things from digital cameras, scans, video images, video clips, but even things, such as EKGs and heart and lung sounds, can be stored into sound, compression wave forms of the ear. So we've kind of become the world's leader in what can you in your store and forward model, which we have found to be extremely efficient when you're working with multiple organizations because you don't have to try to schedule people to be available at the same time. You can capture the data, and the provider can look at it an hour or two hours later. Next slide.

So I work for the Alaska Native Tribal Consortium, and their vision is that Alaska Natives are the healthiest people in the world. So I work for a company that has a vision that we're going to do what it takes to take care of our people and that's part of the reason we do telehealth because, frankly, it's the only way we can take care of folks that live in remote areas, and it's really the Alaska issue. We have folks

that aren't where the doctors. Two-thirds of our doctors are in Anchorage. Two-thirds of our patients are not in Anchorage. So how do you connect patients and providers? So next slide.

The other issue that we face at the Alaska Native Tribal Health Consortium -- and I think you have actually seen this slide at the Commission probably several times from Val Davidson -- is that we're, essentially, a capitated system. We receive funds from Indian Health Service and then we bill third-party payers, but our federal funding doesn't begin to cover the costs of providing the care we need to. So are motivated, highly motivated to look for efficient solutions to provide health care. It has been kind of our bread and butter and that's why we've adopted telehealth. Next slide.

So we started in the 1990s building telehealth. Now we are not the only telehealth system, and we weren't the only telehealth system back then, but we were one of the largest federally funded telehealth systems. So that gave us the opportunity to think broad and large scale and that made us think about, you know, what are the common needs for all our sites as opposed to focusing on the needs of a few sites. And so we really focused on delivering primary care through telehealth, which is kind of rare. Most telehealth programs focus on some of the higher level specialty needs.

So we talked to the health aides, the family physicians,

and the specialists in Anchorage, and we built solutions to focus on kind of our core issues, ear disease, heart disease, respiratory illness, and so forth, and that meant we defined technologies, built it into a small unit that could take up no more than four square feet in the village clinic because space is a real premium in those clinics. It had to be robust, so that children could not go in the back and pull cables out and break the system, which is one of the challenges that we have. And so this thing is locked down. It's hardened. It's secure, and I'm proud to say we have 400 systems out there and very rarely do these things break because somebody has been able to mess with it. Equipment has supply issues, but that's normal in health care. Next slide.

And then of course, we needed to build our software. So we are now listed with the Food and Drug Administration as a medical device manufacturer. We've really evolved to that level. We designed the software with federal funds. It's shared with all Alaskans. Anyone that wants it in Alaska can have it. We have a small distributor business going on, and it's available for sale outside of Alaska, but it's now used in Africa, Panama. It's available in Danish, Russian, Spanish, multiple languages. It's used on the International Space Station. So we're fairly proud that something we developed in Alaska has actually found a niche outside of the state. Next slide.

So the program, itself, has been managed and run by the Alaska Native Tribal Health Consortium. It started as a program under the Alaska Federal Health Care Partnership. It's who, in fact, actually really motivated -- pushed for the funding and wrote the proposal and that's really been our genesis, and we're very proud to have been part of the partnership for many years. We now have a small staff. We've been running for 11 years. We conduct, on an annual basis, about 33,000 cases, which amounts to about 3% of all patient visits in the Alaska Native Tribal Health system, and we are deployed throughout the state. We had 1,500 providers in 2011, and we've seen about -- on an annual basis, about 16% of all Alaska Natives are involved in telehealth, and I tell you those numbers because that's pretty extraordinary. There are very, very few telehealth systems anywhere in the world that can claim that 16% of their population is involved in telehealth or that 3% of their encounters are telehealth encounters. So we should be very proud of the fact that, in Alaska, we have a fairly -- for a small population, we have a very robust, highly used system. Next slide.

So one of the tricks to telehealth is not to pervert the existing referral patterns. I mean, when you're only doing 3% of your cases as telehealth, you don't want to have a completely different way of doing care. So we do follow the standard referral patterns that have been in existence for

decades and were in existence before telehealth. So we follow the concept of villages sending referrals to regions, sending referrals to Anchorage. Next slide.

We do store and forward, as I mentioned. About 75% of all of our telehealth visits are primary care, meaning a village health aide creates a case in the village, sends it to a physician, a regional center, and that's the loop. Twenty-five percent of what we do is specialty care, meaning it would come into Anchorage or to a tertiary care facility for specialist involvement. We use it not only for diagnosis and treatment; we use it for planning, for triaging patients. We actually are -- we know it's being used here and in other sites, notably Billings, Montana, to track and document abuse cases. So it's used for a lot of different purposes.

We also do some level of videoconferencing. That's growing dramatically for us. We use it for cardiology, for screening patients, for follow up in patients, for monitoring patients, transplant patients, et cetera, and you see some other issues there.

On the right, you see the departments at the Alaska Native Medical Center that are actively in doing telemedicine, so it's fairly expansive. And then I threw home telehealth monitoring up there. Sam Johnson will be speaking about that later and will be able to tell you what's been happening in that part. Next slide.

So by the numbers, a very gaudy slide: 130,000 cases, so far; over 65,000 unique patients served; 3,000 providers involved in the system; and almost 2,000 have used our system to create cases. Next slide. So I think John is going to pick it up from here.

DR. KOKESH: Good morning, everybody, and thanks for having me here this morning. So the question, really, is -- you know, the next question is, does telemedicine work? And I'm not going to show you any clinical data. If you're interested in whether it works for clinical applications, we've published quite extensively on that and that's all available to you. And I think, in the last ten years, there is not much doubt anymore that it works clinically.

But what are some of the other impacts of telehealth as it's used in our system? I think one that's interesting, when we asked our customers within the Native health care system, why do you want us to do telemedicine, what's more important to you, I think the answers resonate not just in the Native system but throughout the state with all patients, which is that they want increased access to care, especially for our rural patients. They want access to care.

And second, if you ask physicians, they want what is best for the patient. So that's really what drives us. It's not money. It's what is best for the patients and what's best for access for care. Next slide, please.

One of the problems that we struggle with in our system and I think all rural patients struggle with is that there is a terrible wait time to get access to a provider. There has been some great work done by our partners in Nome, Phil Hofstetter and Jamie Burford (ph). They're right here. They're visiting us today. And what they did is -- they run a big audiology and ENT clinic up in Nome, and we've always had terrible problems with wait times for patients. Kids who need simple things done, often times, are waiting four, even six months to see one of us for something relatively simple.

They put in a system where they used telehealth as the first tool to triage those patients, and the idea was that many of those patients actually just needed the advice of a physician or they just needed to be directed into Anchorage for their care. They don't need to be put into a line to wait to see somebody. And you can see the effect it had, once they put that system in. They went from a situation where almost half their patients were waiting more than four months to be seen by somebody to where, now, there is, essentially, no waiting time to be seen, and it just shows you the tremendous power of store and forward telemedicine in managing groups of patients that need medical care. Next slide.

Diabetic vision screening is very important to make sure that patients with diabetes don't lose their vision. It has to be done on a regular basis. It's very hard for us to do

all the diabetic screening we need to do on our rural patients on the timeframe it needs to be completed on. There is new technology with non-mydriatic cameras that can be used to actually go to those patients and take the images of the retina and then tele-commute them back to a retinal specialist to look at the retina. And you can see, by a pilot project we did using the Joslin Vision Network, that implementing that system lead to an immediate increase in our screening rates, and if you think long-term, if we put that in as a regular feature of our system, we would have much better diabetic screening. We'd probably save a lot on vision. Next slide.

We've done studies to show that we can adequately triage and select people for operations. So in our department, many of patients are seen initially through telemedicine. They come in and meet their surgeon the next day and have their operation the next day. And so for rural patients, and particularly rural patients that are covered by Medicaid, we've pretty much done away with the old way we used to do things, which was fly people into Anchorage for a 30-minute appointment, fly them back home, then fly them back in later for their surgery, and huge savings have come from that. Next slide.

Another way to look at the way we're using store and forward telehealth as a screening tool is that, sometimes, our use of telehealth causes us to get on the phone and say, get

this patient in right way; they've got a problem. One of the scariest things for a provider of trying to manage a queue of patients in a waiting list is that in that list are people with serious problems who are going to get worse, and if we let them wait four or five months before they come to our attention, we might have really cost them permanent disability.

This shows you, in our current system, about 10% to 15% of our cases result in us traveling a patient right away for care and that's actually a really wonderful thing that this system has allowed us to do. If we're going to have a waiting list, we want to make sure that we're managing it appropriately so we don't cost people morbidity or even mortality. Next slide.

When done on a large scale and when resourced appropriately, you can get some tremendous results from telehealth as far as speed of reply. This is data from our institution, and you can see that, currently at the Alaska Native Medical Center, most telehealth cases sent to our institution are turned around the same day, and almost 30% of the cases are turned around within an hour and that just -- you can build a system to make it do whatever you want, and Phil, who practiced in New York prior to coming to Alaska, has always told me that he never got service anywhere close this good when he was in practice in New York. So even though

we're a big state with huge infrastructure problems, this is a real beautiful solution to some of those problems. Next slide.

And speed of reply is really important to patients and providers. This is a survey we've done in the last year of our providers, and speed is really important. It's hard to deliver care, and if you get the answers out to people right away, it really makes things flow much better. Next slide.

I know there are a couple physicians around the table here. I think anybody who has worked in a medical practice learns to hate faxes. Faxes are really difficult to deal with. Critical information sits in a pile of paper. You don't get it in time. Things get lost. We've used our store and forward system pretty much to eliminate faxes. I think, at least, over half the faxes at our institution are now gone, and I think we're on about a one-year timeframe to -- we'll probably turn off our fax machines for good. So there is a better way now to transfer information, and the store and forward telehealth solution is a much better way to do it. Next slide.

The business case for telehealth, we're struggling with that right now. I'll go through some of these slides. The problem we're having at our institution right now is that the way that telehealth is done and the way it's reimbursed it's actually difficult, from a business standpoint, to make the

argument that we should continue to do it and do more of it, and I'll just go through some of that right now.

When we do a telehealth case in the AFHCAN system, every case that's done we ask the provider, did this telemedicine case prevent you from asking us to fly the patient in to be seen by you? When I leave this meeting, I'm going to go to my office right now, and I'm going to meet a patient who I got a call last night who is flying in from Kotzebue. I'm told they have a particular problem that may need an operation, but I have no idea if they really need it. Chances are, at least, 50% I'm going to do a 15-minute exam on that patient and fly him right back up to Kotzebue, you know, on Medicaid travel dollars. That's in the system because this particular partner doesn't use telehealth the way we'd like them to use it, but when used properly, we can really track how much travel savings we think we're avoiding. So we can estimate on any patient, if I had asked them to fly in, how much would it have cost somebody, primarily Medicaid, to send that patient in, and you can see, on a yearly basis, we're tracking about -- avoiding about $3 million of travel costs and that's not surprising. When you think about a two-year old having to fly in from Noorvik, that's a child and a parent having to do a flight from Noorvik to Kotzebue to Anchorage round-trip. That's a lot of dollars. It doesn't take long for you to reach that kind of cost. Next slide.

In fact, we did a study of our Medicaid covered patients from 2004 to 2009, and what we did is exactly what I just described. For all the Medicaid patients, we looked at the avoided travel, making those calculations, and then we kind of compared it to what Medicaid was reimbursing us for the store and forward telemedicine. Now Medicaid has been great in working with us because, in most states, Medicaid doesn't reimburse for store and forward telemedicine. We were really on the forefront of that. But we wanted to really look at what Medicaid was getting out of the system, how much were they paying, and then how much travel were they avoiding. Next slide.

And this is the story right here. For even simple problems, you have to fly all these different legs to get a patient in front of a provider to deliver the care, in a lot of cases. And our data would suggest that, somewhere between 60% to 70% of those cases, we can avoid those travelings by using telehealth more effectively. Next slide.

And what we found in that study from 2003 to 2009, which we are, by the way, updating here with fresh data, is that, basically for every dollar that Medicaid spent on reimbursing us for our telemedicine reads, they saved about ten dollars in travel costs. So it's a pretty strong argument that it was money well spent and perhaps maybe we should try to do more of it. Next slide.

Now interestingly, when you look at it from the physicians' standpoint and the institutions' standpoint, this is becoming more and more important as dollars are getting tighter. At my institution, we just bought a $35 million electronic health system, like most institutions are doing around the country. It's made us -- it's taken a lot of money out of -- from other things, so we're really tight right now, and we're looking very carefully about how we're using our physician time and what are the costs and benefits of doing certain types of medicine.

Well, what we've learned about telemedicine over the years is that the way that we agreed to have it reimbursed using the existing evaluation and management system, which is the same system I use when I see a patient in clinic, telehealth really kind of walks you into lower levels of reimbursement because the rules are based on number of body parts examined. So the vast majority of our patients seen by telehealth are seen at the lowest level, which reimburses at the lowest level. When I see a patient in person, I code, at least, at a level three or four, which is a much higher level. So on a provider pro-fee basis, we take a hit every time that we do a telemedicine case as opposed to having a patient travel in. So from a strict financial standpoint, far better for my practice to insist that you fly everybody in to see me, and we're starting to realize that more and more now.

Also for telehealth, we don't get a facility fee, and you know, that's a huge part of our reimbursement on Medicaid patients in the state. So those two features make it pretty clear that, from a revenue standpoint, telemedicine really doesn't -- you can't make the argument for it. From the standpoint of patient care, certainly, we can make the argument for it and so that's why we're continuing to do it, although I think we need to revisit it, at this point. Next slide.

So the challenges. You know, there are competing forces in health care. The dollars are tight. We're having to justify every minute of a provider's day. And then the EHR has really made things a little bit tough on us because it's more labor-intensive, actually, to fit telehealth into EHRs and that's a bigger topic that we can talk about for hours, but you know, we need to probably look at what are the drivers of telehealth and make sure that, at least, there is not a financial disincentive to doing it. Next slide.

DR. FERGUSON: So we're going to return, at the end of this slide, to some recommendations based on the analysis of costs and the revenue and the business model. I thought what we'd do for the next few minutes though is go look at some other programs, some programs that were actually models for many other folks who do telehealth, and I think it's something we could learn from. So next slide.

I'm going to look at two programs today. One is based out of Boston. The other is based out of Ontario. Some of you may be familiar with this, but in Ontario, you know, they have mostly a single-payer model. About 70% of their health care is paid through provincial health care, so obviously a very different model than what we have. But what they have done, as a province, is they have taken three different telehealth networks and made them one telehealth network, and it just shows you the power of what happens when you have a centralized model for kind of connecting providers to patients, and it's something, I think, that might be interesting for us to look at, so next slide.

Ontario is about two-thirds the size of Alaska, has many, many more people, 13 million people. So they, as a province, have tried to build a system that reaches to all those sites. Next slide.

So it's called the Ontario Telehealth Network. It's led by a physician, Dr. Ed Brown, who actually will be the president of the American Telemedicine Association after me. So we're very close colleagues, and we visit his sites, and we try to learn from what they do. I have to say they're doing a tremendous amount of videoconferencing, but almost no store and forward, and they actually want to use our system to do store and forward and learn from us how to do that. We would like to learn from them how to do kind of statewide video. So

it's nice to have these relationships. But they have 1,500 sites, so a fairly large system. They added as many sites in 2011 as we have in the state of Alaska, so they're fairly large. Next slide.

So in terms of clinical events, they did about 200,000 events last year. We did 33,000, so about six times the numbers, but they have almost 20 times the population. So you know, relative to the population, we're doing more. They're seeing a 50% growth. We're seeing a 50% growth in utilization per year, so similar rates of growth. They have about 1,500 consultants. We have 1,500 docs. So there are some similarities here. Next slide.

This is what's interesting. With 200,000 video consults in their system, they still are seeing the same thing almost every telehealth system in the world sees, which is the majority of the uses for video are telepsych and mental health. That's not surprising. And what's not surprising in Alaska is we have a real need for telepsych and telebehavioral health and telemental health and suicide prevention and some of those issues. And what they've discovered is, as a province, when they build kind of a unified scheduling system and can connect the people with the providers, they're able to do a lot of mental health over video. We do some, but we're nowhere near, I think, where we could be. Next slide.

In terms of travel avoided, the top line is kilometers.

The next line that has $45 circled is travel avoided and that's millions. So they save about $45 million a year. We, in Alaska, save $3 million on specialty and $3 million on primary care, so $6 million. When you think about it, they're saving about eight times what we save, six to eight times. They're doing about six to eight times as many consults. So we're in about the same ballpark in terms of how much we save relative to our usage. Next slide.

But because they have this province-wide 24/7 system -- and they're really kind of a giant switchboard is how I look at it. Any patient at any of their sites can ask for a consult. They track several thousand providers. They know their schedules, and they can link anybody up with anyone else, but because of that, they can do 24/7 urgent care province-wide.

Telestroke is an option for them, and they've 203 tPA deliveries. They can do crisis psychiatry, 911 calls. You know, those are issues that we would be -- we're really challenged to provide in Alaska, but they've built the system, and it works. And I'll just say this right now. In the tribal health system, we're trying to build up some capacity for 24/7 calls, but it means that we need network engineers. We need videoconferencing to work. We need to make sure it works when the doctor is needed. Well, the same system would help Prov and the VA and the other systems. So it's really a

state problem, not a tribal problem. And we're challenged to fund and resource that, but these are some of the things that can happen when you have that kind of an approach. Next slide.

So what do they do? I think the key thing is they are a single kind of point for centralized services, such as trainings, scheduling videoconferencing, reporting, and they help drive adoption. AFHCAN has been able to do that from a store and forward perspective. We have a single kind of software platform. We have centralized training capacity and so forth, but we haven't branched out as a state to look at how we would do that for video in some of the urgent care. So it's just something to consider. Next slide.

This is a slide that's not in your packet, but this is their vision. Their vision is that, within a few years, they're going to have a million patients served annually. They're going to have 40,000 patients enrolled in home telehealth monitoring to manage their chronic disease. They've done a pilot where they've targeted the most expensive patients and tried to decrease their utilization of the system, and they believe, and the province agrees, that they should be targeting 40,000 patients. Huge. Next slide.

So I'm going to talk a little bit about home telehealth. You're going to be hearing, I think, from Sam Johnson later today, and I just want to show you what's happened in some

other programs.

So one of our challenges is we have so many chronically ill patients in every system that they place a huge burden on the hospitals, the EDs, and so forth, and they place a burden on Medicaid and Medicare and all of the payers, and we don't really target them and try to reduce those costs.

So what they did in Ontario was they did a pilot, and their pilot could be like everything we need, but they did 800 patients as a pilot, but they say about a 60-some percent decrease in hospital admissions, ED visits, visits to their primary care and walk-in. Now they're not alone in those kinds of return, but you know, when we're an underfunded tribal health system, anything we can do to keep folks healthier and out of the hospital helps us and it helps the payer plans. Next slide.

So I just want to kind of show you some other data to support this argument, and this is Partners in Boston. They're a little bit like an HMO. They take care of their patients. Next slide.

They actually have two different home telehealth programs, telemonitoring and a cardiac care model. Next slide.

And they get similar results, but here's what is interesting about their study is they found that 100% of their patients have, at least, one hospitalization prior to being

put on their monitoring system. They put them on the monitoring program for four months, very intensive, a lot of coaching, calls every day, and then they took the equipment away, and a year later, those folks were using the hospital half the rate they were before, 50%, and it sustained. In other words, this is not necessarily something you have to do forever. It's something you can do and try to change people's behaviors, lifestyles, and try to decrease the long-term costs to your system. Otherwise, what you see is the costs just keep skyrocketing and going up.

The lower line is those that actually had a heart failure hospitalization, and they went from 40% of them being hospitalized for heart failure down to 13% and that's a year after they came off the program, so something to think about for Alaska. Next slide. Go ahead.

DR. KOKESH: Next steps. So you know, what's possible and what are some ideas on how to move things forward? Next slide.

So when Stewart and I were thinking about this, we decided to make a slide that had two columns in it: what was the interest of the tribal health system, and what was the interest that we thought the State had? And we started making these columns. Then we realized that, well, you know what, it's the same interest for both of us, and we don't really need to separate it that way. In fact, it's the same interest

for the State for Native patients, for non-Native patients, for veterans. It's the same for everybody. So we all desire greater efficiency for our providers. We want to get the most for the dollar. We want to reduce readmissions, spend less on travel, stewardship of appointments, make sure that the patients are seen by the right provider at the right time for the right price, slow the growth of expenditures, deliver more care at home. These are all things that everybody wants, and you know, there is no reason we can't move together on it. It benefits everybody. Next slide.

So there is definitely a shared interest, but I think one thing that we realize is that there is no stated vision that helps us guide how to move forward, and I know, at the Tribal Health Consortium, we've always had -- our vision is that Alaska Natives are the healthiest people in the world, and when I came here 18 years ago, it didn't mean much to me. But what I've seen happen over the years is that, as people come and go, we still keep that vision, so that kind of dictates everything we do. And when I hire a new provider, we tell them right away, this is our vision. So this is where we move towards. And so I think visions and missions are actually really important. Next slide.

So maybe the first job is for the State to create a telehealth vision. What really do we want to accomplish on a long-term basis? What do we want things to look like next

year or five years from now? Next slide.

So here's an example that Ontario Telehealth uses. Their vision is that "telemedicine will be a mainstream channel for health care delivery and education." Next slide.

The American Telemedicine Association, their vision is that "telemedicine will be fully integrated into health care systems to improve quality, access, equity, and affordability of health care throughout the world."

So there are visions out there. I think, you know, there should be some discussion, and the State should decide how they think telehealth fits into how health care is delivered now and in the future. That's probably the first step. Next slide.

An easy thing that could be done -- well, not easy, but one of the first things that might be done is to mandate reimbursement for telehealth for private insurers in the state. And right now, in our institution, this is a major pain for us. So the private insurers sometimes reimburse us; sometimes they don't. It's capricious. It's not anything we can count on. Next slide.

Other states have done this. So right now, there are 15 states that basically say, if you're going to come and do business in our state, if you're going to sell health insurance in our state, you have to reimburse for telehealth

the same way you reimburse for anything else, and maybe that's one of the first things that can be considered. That helps us plan things in a little more predictable fashion, at least. Next slide.

And so this slide I don't need to go over. There are a lot of different ways to do that, and I'll, you know, leave it to you to look at later. Certainly, there are a lot of models out there that you can go look at and figure out what works best for our state. Next slide.

The next step: develop a statewide strategy that would benefit all people in the state. Next slide.

So what's really possible, if we move forward and get this right? Next slide.

This is data that we collect at the Tribal Health Consortium about Alaska Natives. These are the leading causes of death for Alaska Natives in our state, and I would, you know, draw your attention to suicide and unintentional injury. It's almost 20%. That's pretty high for a population. Next slide.

When you look at the years of potential life lost -- so you weight higher an unintentional death for a 20-year old than you do for a 80-year old who dies from cancer. Well, these are the numbers from our institution. It's really terrible for unintentional injury and suicide. So what does that relate to? Mental illness, substance abuse, alcoholism.

Those are huge and terrible numbers. Next slide.

Hospitalizations by Diagnosis Groupings. So one of the highest ones is complications of pregnancy and childbirth. So could we possibly do a better job of prenatal care if we had a robust and reliable telehealth system? Next slide.

So if we make store and forward telehealth more predictable and more widespread, have it benefit all people in the state, not just Native patients in certain areas, if we had a videoconferencing system, that would allow providers in the state to really count on it, you know, the way that I count on a telephone. I pick it up and make a call. I know it's going to work.

What would that allow us to do? Well, we could start to provide more telepsychiatry, which is an enormous need in the state. We could have home telehealth for our patients with chronic illness who cost us more money than any other group of patients. We could start to do what one of my colleagues -- Dr. Matt Hirschfield (ph) is in the audience today. We can't deliver the level of pediatric specialty care for patients in rural Alaska. When we have a child who has a serious endocrine problem, we're lucky to get them in front of an endocrinologist in Anchorage once a year. If they lived in Seattle or Portland or Iowa City, they would be seeing an endocrinologist once a month. And with a robust and reliable videoconferencing system, we can probably make that happen by

videoconferencing. In fact, Dr. Hirschfield has made connections around the country with specialists who are willing to do that work for us, if we can put together the system that will allow those connections.

At the Tribal Health Consortium, we have a problem with pain management, and we've already with, I know, Dr. Stinson. Although I've never met you, I recognize the name. We're talking about using videoconferencing and these types of tools to help patients make connections with people in the city here who can help us deliver that care. So there is a lot that's possible, once the infrastructure is put in place and once people can seriously talk about how we're going to use it clinically. Next slide.

So just as a something to consider, something to maybe bring back and have the Commission think about, you know, what are the type of pilot projects that we could do to maybe see if this would really work? The nice thing about pilots is that we can do them for a while. You don't have to commit to them forever. We can see if they work. We can see if they really deliver as promised.

So for store and forward telemedicine, we're doing a lot of it right now. It's working pretty well. I think that we've shown, pretty effectively, that it's saving a lot of travel costs, and it's probably saving in clinical costs. But you know, I think the reimbursement for it is not right. And

so it's certainly not to where it promotes usage. And so maybe let's think of some strategies to maybe do reimbursement slightly different to try to promote usage, promote the use of it for greater populations of patients and see if that will help accelerate the travel savings. I don't think we've exhausted this. I think we're just scratching the surface of what could be saved with that.

It also will help us develop new care models. So I think other specialties, other types of care will start looking more seriously at how to use store and forward telehealth. Next slide.

With regard to video-teleconferencing, again, we probably need to look at reimbursement models, so that we develop new types of delivery systems, create it so it's more reliable, and probably one of the most important things with videoconferencing that we've learned from Ontario is that we really have to have a central way to manage the network, to make it easier for someone to rely on the network, scheduling support, to make it more like the telephone system rather than a one-off type thing where I have to make 12 phone calls to Stewart to make sure it works tomorrow for me. Next slide.

With regard to home health monitoring, you know, a great project, a great pilot would be to look at our chronically ill, high cost patients and see what can happen if we bring home monitoring to them and use it in the way that it's used

in Boston with Partners. That model is being used all over the country, and it seems to work pretty well, though it does take an infrastructure to make it work. Next slide.

So basically, I think, to sum up our presentation, there are lots of common interests between all the constituents in this state, Native patients, veteran patients, non-Native patients in rural Alaska, even patients in the urban areas, common interests with the State and with the medical community, and it's a natural situation for partnership in moving forward. So thanks for your time this morning.

CHAIR HURLBURT: Larry?

COMMISSIONER STINSON: As you mentioned, I've been to ANMC, and I worked with one of your colleagues on some store and forward ENT cases from around the state. I was blown away the degree of detail that you can see in the blow up images of the tympanic membrane and they could do movement. They could -- they did other testing. It was as good or better than if the patient was in the room with you. This needs to be encouraged. I cannot imagine that this would not be a huge savings.

I have a meeting later this afternoon to do that for other specialties through your system, and you also have the benefit of having boots-on-the-ground, so to speak, with the health aides. If you can have people there and teach them what to look for and how to present the material to the

physicians who are more centrally located, you could get to the underserved different populations, and it's just not Native. It's rural for everybody in this state. You were talking about two-thirds of the physicians are in Anchorage. Well, if you go out of the tribal system, I'm sure that those ratios are about the same for the non-Native health care populations, too. The benefit of this would be enormous. The cost savings would be enormous. The transportation savings would be enormous. We've already seen what some of the air ambulance costs have been in previous testimonies. Some of those were unbelievable. So to me, this is just a no-brainer.

COMMISSIONER HARRELL: So Colonel Harrell from out at JBER. First of all, excellent presentation for the both of you. From a DOD perspective, we're not strangers to this because we have a lot of high demand/low volume specialties spread out all over the world. So we've been dipping our toe in it, here and there, over the last ten years.

I'd like to get down in the weeds a little bit in two different areas though in your presentation. I'm curious regarding your statistic on 75% of your primary care were engaged in the store and forward. Of what flavor is that, is that a generated consult out to a specialist that then awaits a response? How do those stack up in that 75%?

DR. FERGUSON: So what we call primary care is when we see a telehealth case that's created almost always at a

village and it's reviewed and responded to by a family physician at the region, so it never leaves the organizational boundary. So a good example would be somebody at, you know, Noorvik sending a case to Kotzebue to the Maniilaq Health Center. And you know, they do a lot of radio-medical traffic, and they do a lot of communication with health aide, but now they use telehealth for part of that process.

COMMISSIONER HARRELL: So a mid-level to an upper echelon?

DR. FERGUSON: Yeah. Almost always health aide to family physician. Right.

COMMISSIONER HARRELL: And then secondly, with your store and forward usage, are you incorporating secured messaging in that or is this provider-to-provider talk?

DR. FERGUSON: In terms of the -- I'm sorry; which part?

COMMISSIONER HARRELL: In terms of a store and forward type of mechanism, is that still provider-to-provider, clinician/clinician or is that incorporating a patient reaching into your system with a question directly to a provider?

DR. FERGUSON: So no. In this case, it's all provider-to-provider.

COMMISSIONER HARRELL: All right. And then on a more professional staff note, as you've moved to your EHR, have you seen any impact on the documentation burden in the EHR and

your ability to maintain effectiveness in your telemedicine/telehealth? It's a loaded question for you. We have an EHR, as you know, in the DOD, and we experience some frustrations. So I'm very curious, particularly to try to move this forward, have you assessed the impact on an EHR?

DR. KOKESH: Well, interestingly, we just looked at some information yesterday that showed that, when we went to the EHR, actually, our use of store and forward went up, and I don't know if that's really related, but I can tell you from a clinical standpoint, a personal standpoint, the burden of provider time has increased dramatically with the EHR coming in, making it even more important that we use tools that increase our efficiency.

So now that my face-to-face encounters have increased in time and not so I can talk to the patient more, but so I can fight with the EHR more, it makes it even more attractive to use this other tool. My ability to deliver care is just as good, but in a much more compressed time.

COMMISSIONER HARRELL: So that was a personal question that I teed up, in terms of that, when the Commission looks at this and where you want to go, the evolving EHR has a dramatic impact on the ability to utilize telehealth, and in fact, will drive more telehealth because of the man on provider time and system time.

And then now just on a follow-up on a data piece, I noted

you had the 203 tPA deliveries, presumably, through e-consultation, videoconferencing with a stroke patient. I'm very curious as to outcomes data on those 203 deliveries of tPA. Do you have any outcomes data to report on that?

DR. FERGUSON: I can get those for you. That's coming out from Ontario Telehealth Network. Yeah.

COMMISSIONER HARRELL: I think that's important to keep in mind because there is anxiety about not having a provider face-to-face, particularly in these high risk decisions, but if you've got outcomes data that says, hey, we did this via video monitoring and here is the outcomes data, and it's comparable to "I just laid hands on an individual," that's powerful in terms of being able to promote the telehealth and the use of e-consultation, particularly eICU consultation. And I think, in this state in particular, eICU consultation, electronic ICU consultation, is a significant thing to be looking at. Your access to specialty care and your ability to treat a patient at distance has significant impacts on costs when you're starting to talk about air ambulances and critical care settings. Those prices are just unbelievable. Thanks.

DR. FERGUSON: Just as a follow-up, you'll be hearing from Christie Artuso from Providence about their program here. In general in the world of telehealth, the ability to administer or not administer tPA and to do telestroke is kind of a no-brainer. People are doing it. What's happened in

Alaska is almost all of our small regional hospitals now have CT scanners. So suddenly, we can actually talk about doing telestroke and then you start to talk about a small flight from a village to a region and you can start to do telestroke. But just keep in mind, in order to do telestroke -- and we're actually worried about it -- is that we have to have, you know, 24/7, no-fail videoconferencing available. It has to work when it has to work and that has a cost that rides on top of the cost of the physicians, and we're not really scaling and designing systems to provide that. Once you do it, then telepsych and 911 and all those other things flow naturally on top of your telestroke model.

COMMISSIONER HARRELL: It's an interesting inversion because, when you approach telehealth, you typically start with the lower acuity concepts, but if you turn it on its head and you look at the higher acuity, and as you just said, you build a system that deals with time-sensitive care delivery, the rest of it all flows very nicely after the fact, and there is much less risk associated with it.

COMMISSIONER DAVIS: Jeff Davis from Premera Blue Cross Blue Shield of Alaska. An excellent presentation, I echo that.

A couple of things first. I'm trying to figure out how you take what you have done, which is really remarkable, and expand it to the whole. And you know, you've kind of got a

captive audience on both the provider side and the owner/user side. So how do we bring the -- how does the private sector also come into that in a seamless way without duplicating all of the infrastructure and effort? I'm sure you have a vision for that, and I've been sitting here trying to figure out what that would look like, and I, apparently, am too limited intellectually to do that. So I'm interested in your thoughts.

DR. KOKESH: Sure. So my experience of the world and what you're talking about is that I go out to the Bush and I see patients primarily in the tribal health system; however, since I am in an area where there is no other health system, I also see non-tribal patients, and I have to deal with them somehow. So tribal patients, no problem. I have a system. I know how to use all the tools, including telehealth, to get them in. That same situation, once I see someone out there who needs services from the private sector, all I can do is write a name on a piece of paper and say, well, try to make your way into Anchorage and see if you can get somebody to help you.

I think what's lacking -- and Dr. Stinson can maybe help me with this -- is a predictable reimbursement strategy to make it worth the private community here to develop a relationship with me, so that they will accept what I send them by means of telehealth and use it as part of their

regular practice. So if my colleague in town here who is organizing his or her day, it needs to be worth their while to know that, from 3 to 4 o'clock, they're going to sit down and they're going to do their telehealth cases. And we're struggling with the same thing at our institution, but I think that's really what's lacking. The case for making that part of your regular work doesn't exist right now. So as a result, I have no place to send that case that's going to get it accepted.

And worse yet, you know, those models are actually getting developed outside the state. So then I'm going to have the really bad option of telling people I'm going to send their case outside the state when, really, telehealth only works well when it's married with the face-to-face system because a lot of those patients actually need something done, and I don't want to tell somebody, well, the doctor in Florida thinks you should come down there and have a biopsy done. That doesn't work for them.

COMMISSIONER DAVIS: No. Well, I was afraid that was the answer. So thank you for that.

DR. KOKESH: I knew you were afraid of that, too.

COMMISSIONER DAVIS: Yeah, because, you know, that means that it's not just as simple as a change in reimbursement, but it's also changing practice in one practice at a time around the state to make that available, but not to say that that

can't be done.

DR. KOKESH: But it's a small state though.

COMMISSIONER DAVIS: It is small state; true.

DR. KOKESH: So that makes it easier here.

COMMISSIONER DAVIS: That makes it much easier. And follow the money. You know, you're right about that. And with respect to reimbursement, I believe that -- well, many years ago, our company made the decision, if it's a medically necessary visit by a licensed practitioner, and you know, it meets all the other criteria, why not? So hopefully, that's still the case. I will be following up today. But I would support your concept of making it mandatory because there are others who, undoubtedly, act differently.

And then to your last point, the question I had was, do we have licensure issues? I mean, let's just imagine a positive scenario where there is a specialist unavailable here, the endocrinologist example you gave, and that endocrinologist is in Washington or Oregon or wherever around the world. Are there currently state licensure issues with that provider rendering care to someone who is physically in Alaska, do you know?

DR. KOKESH: You know, that is an issue in the whole worldwide telehealth -- nationwide telehealth community in that you have to be licensed in the state that you're delivering the care to the patient. And if you're thinking

about a system where you are sending cases anywhere in the country, that can be a problem. However, the way it is played out in our system is that we go to providers.

So for example, Dr. Hirschfield is going to a pediatric rheumatologist in another state and saying, hey, would you like to do this work for us and let's work something out. When you do it that way, then it's really not a big deal to say, I'll tell you what; we'll help you get an Alaska license and we'll guide you through that whole thing, and as part of the licensing process, we'll make sure you are credentialed at these hospitals. So we're not talking about having to do that for hundreds or thousands of providers around the country, but more so for targeted people who probably have a relationship with working us anyway. So it's actually not as big of a problem here as it is when you're thinking about a system where you're trying to have 500 dermatologists all over the country and figure out where the best place is to send them, you know, based on what they're going to charge you and that kind of thing. So it's not as big of a problem here in the way we generally do our medicine.

COMMISSIONER DAVIS: Well, thank you very much for enlightening me. I appreciate it.

CHAIR HURLBURT: Representative Keller?

COMMISSIONER KELLER: Yeah. This is kind of a good follow-up for that. I really appreciate the fact that you are

bringing before us the proposal to look at the business aspects here.

It was about ten years ago when I came over to your facility and looked at it. This information about the savings, the potential savings was clear. It was there, and everybody knows it.

So we've got this potential savings, and it sits there year-after-year. You know, this goes on and on and on. And at some point, you know, this may be a great opportunity for this Commission to try to get a business model, how to translate the potential savings into profit available on a fair basis to the providers. I mean, your suggestion of a mandate sounds good. I wish Linda was here because she could help me here, but that won't work. I mean, it won't work from a legislative perspective. I'm not -- it's not real clear, to me, what the Department can do in that arena, but legislatively, we only have jurisdiction over -- we don't have jurisdiction over self-insured, you know. So that -- I mean, there are a very small amount of things we can do with statute. But if we put some money out there and we -- you know, I could really get excited about that, and the Legislature could help there, and the Governor, of course, could, you know, lead the way -- you know, this is all potential -- in coming up with a plan so this potential savings could actually be turned into increasing our supply.

You know, I mean, more doctors -- if a doctor from Florida looks at Alaska, well, I can go to Alaska and put up a practice. In the meantime, I can pick up X amount of dollars because I can take telemedicine cases here, you know, and have that profit and translate that, and guess what, we've got doctors coming this way, too, you know.

So you know, this is just an idea, but maybe we can encourage, as one of our recommendations, you know, a business plan to try to translate this potential savings into profit.

CHAIR HURLBURT: David, did you have something? And then Larry?

COMMISSIONER MORGAN: Yeah. I guess I better self-declare before I go.

I've been working with Dr. Hirschfield a little, and over the next few weeks, especially in the area of pediatrics and the (indiscernible - voice lowered), which is a very high cost specialty where you need to have periodic visits, but some of those visits can be done by telehealth, but the barrier, besides some technology barriers, is basically coming up with -- the way the reimbursement system -- like what you were describing, Colonel, has kind of got it upside-down, and so basically, we're going to propose, once we get it through our bureaucracy, which we have a bureaucracy, too, a possible pilot program to also track -- in my mind -- this is just in my mind -- also tracking, besides the travel cost savings, but

also possible hospitalizations, but with this controlled group, it would be very easy to be able to do a study that would say, if you weren't doing it this way, what would it cost, and if you were doing it this way, what did it cost and what were the savings?

But primarily on the reimbursement end and using these physicians from out of state, the pilot project would have to have some tweaking there. It becomes, basically for the physicians or the organization that's doing it, cost-prohibitive from a reimbursement side to fund it, to do it this way.

So you'd still have significant savings to an insurance company or to a self-insured business or to Medicaid, but on the other hand, we can't -- inside of a one-to-ten ratio, you know, I would think a two-and-a-half-to-ten ratio would be better in the big picture, if you understand where I'm going with that.

So anyway, I just wanted to a) get it on the record I'm working on that purely on the financial end. I am helping put together the proposal. Dr. Hirschfield and several of his colleagues are the brains behind the pilot project. But I think we'll probably have a couple of those to bring to the health system to see if what we can do, and we should be able to track those costs and units, if we can get the pilot project approved.

So I thought I better get that on the record, and it's been an interesting process for me to sit down with Dr. Hirschfield and his colleagues and go through this. I kind of felt like I was playing so high over my head, my nose was bleeding through it, but we were able to get it down to a four-page proposal, but it'll be quite interesting.

What I liked about the pilot is it's not a huge number of patients, but they are spread over a big geographic portion of the state.

CHAIR HURLBURT: Larry, then Keith, then I have one. Go ahead.

DR. KOKESH: I did, just real quick. There are just a few things I've heard here I want just to clarify.

While a robust store forward and videoconferencing system would allow us to make connections with physicians outside the state, that's really not our biggest need. Our biggest need is to get more out of the physicians we have within the state, and there are plenty of good physicians. We have most of the specialties within the state. We can get more out of them if we make a more reliable way for them to reach out into the rural areas. That's the first point.

And the second thing is that, as you move forward in this and as you think about how to better reimburse for telemedicine, telemedicine is essentially different, from a reimbursement standpoint, than what we've been doing for the

past 50 years, and in one way, is that there is effort and time and expense on both the sending side and the accepting side to do telehealth, and traditionally, we've only reimbursed the accepting side when we talk about consultation, and we've got to be really careful, as you move forward, that that reimbursement is on both ends of that or you won't get the bang for your buck that you would hope for.

COMMISSIONER STINSON: Good points on both of those things. Yesterday, we had the VA and tribal health work together to come up with some solutions to seemingly previously impossible problems, and it sounded like sequestered in Barrow may have been the key; I don't know. But I would think some of those same issues, maybe some of those same people could be involved because there are VA patients out in the Bush. There are the Medicaid patients we've already talked about. There has to be internal agreements between a lot of these agencies, which, my understanding previously, impenetrable silos, but somehow got worked out. Maybe that could be a template to go forward, one.

And then two, the other issue with private physicians and actually maybe putting yourself out at risk when you see the non-tribal people is always malpractice, and if you tell somebody no, you don't need to come in and they perf their eardrum or whatever, that's an issue. So when it's within one

system, that may not be -- or the DOD system, that may not be as important as when you're starting to mix the systems and that's another consideration.

COMMISSIONER CAMPBELL: My question is more of a technical one. You talked about the need for the 24/7 switchboard type operation. Recognizing we've got basically three systems in the state, the private, the tribal health, and the VA, would you visualize three different switchboards or an integrated one statewide?

DR. FERGUSON: So to me, it would have to be one. It wouldn't be that hard to do one where, for instance, Prov can participate, and we actually do this, to some extent. The tribal health system connects to -- has connected to the Providence system and to the Alaska Psychiatric Institute. So I imagine it would be one system where we can actually connect the folks with who they need to connect, especially on behavioral health. We don't have a lot of resources for telepsych, mental health, and behavioral health in the tribal health system. So we'd have to build a system that connects kind of on a statewide model.

COMMISSIONER URATA: This is just a comment on a possible solution for the reimbursement. It sounds like the RVBUs have to develop a new program for telehealth, you know, and not use the E&M coding system because telehealth is so different than E&M and that seems like that would be easy to do.

CHAIR HURLBURT: Let me ask a question and then Allen, and this is a little bit of devil's advocate kind of a question and interested as to what's in progress because, for example, to get Premera -- Jeff's not the only person that you have to convince -- you have to convince a CFO, and generally, financial types will be a little skeptical of docs' numbers on what we claim.

In looking at -- but the CFO also, the Premera or any other payers' financial survival is going to relate to what are the bed days, how many MRIs are we getting, and very few CFOs are not going to want to do the right thing, but recognizing that they're unavoidable bed days are unnecessary (indiscernible - voice lowered).

When you look at the impressive graph that you showed of the reduction in bed days of heart failures patients, for example, do you have a comparison there? I assume they were not randomly selected to have a comparison group, but to what extent can you say with assurance that wasn't regression to the mean that you would see with a high utilization group that's having a bad year and then might get better? Now I know most heart failure patients don't have miraculous cures, but have you tried to analyze, for that, to solidify the data that you have?

DR. FERGUSON: So we don't have the data for Alaska patients that would show that, so we really have to rely on

the data that comes from other systems, and I showed you two examples. There is kind of an overwhelming body of information out there that the normal model is, of course, you've got to be selective in which patients you pick. So you have to pick the patients that have the potential to save the system costs, the ones -- the high users, the people that typically show up in your ED or your hospitals, and then you have to look at, for the states that you can monitor as well as you have to put in a compliance measure. But when systems select the patients that have the greatest chance of saving the cost, they typically see -- and it varies from about a 30% to a 60% drop in hospitalizations and ED visits, and it seems to be consistent across different programs. So there seems to be a general consensus in the telehealth world that this is the model to use.

I think what's going to happen though is, once you take care of the low-hanging fruit and you take care of the expensive patients, what happens next? You know, can you take 100 patients and say, well, it worked for those, so we can take 10,000 patients? And I think that's the challenge, to figure out at what point do you get diminishing returns? But that's why I think you do a pilot and you start to try to look at some of those models and figure out, from a financial perspective, where you need to stop the project, but we haven't done that, even in Alaska.

DR. KOKESH: (Indiscernible - away from mic) low-hanging fruit. So for example, when we were talking about the pilot project for home health monitoring, if you think about chronically ill patients in rural Alaska, you know, even if we don't prevent quite as many hospitalizations as they have in Boston, for example, every patient who is chronically ill who has any problem is highly likely, in this state, to get Medivac'd someplace to get evaluated, and I've seen the Medicaid numbers on what percentage of Medivacs actually result in a hospitalization, and it's kind of shocking how much we fly people around, just to decide they actually don't need to be in the hospital.

So I think, if we did a project in rural Alaska, you'd potentially see even greater results than you do in a place where -- you know, in Boston, all it's going to cost you is a bus ride to the emergency room. Here, it's a Medivac to the next place you go for care.

CHAIR HURLBURT: Thank you. Allen?

COMMISSIONER HIPPLER: Thank you. I'm curious as to your experience with your malpractice insurance carriers, and in general, your experience with malpractice after you got your carriers to agree to this.

DR. KOKESH: So I have one experience with malpractice carriers as it relates to telehealth and that was, very early on in our experience with telehealth, Dr. Tom Nighswander, who

I think most of you know, said, you know, you really ought to go down and talk to our carrier and see what they think about all this. And so we went down to San Francisco and met with the board of Norcal, who does our -- you know, I'm covered by the federal tort claims, but Norcal does our secondary coverage. And basically, they had a big day meeting talking about telehealth, and what they basically said is that, from an overall standpoint, our interest is reducing our entire risk pool. So anything that you bring to us that makes it more likely that people get appropriate consultations on time, that right decisions are made rather than wrong decisions is, overall, going to reduce our risk pool. So our decision is that we will cover you, you know, as long as it's within your scope of practice. You know, if I render an opinion about someone's coronary artery disease, if that's not within my scope of practice, they're not going to cover me for anything I do there. But within my scope of practice, my insurance covers me. We actually have not had -- in the ten years we've been doing this, we haven't had any claims related -- we haven't been able to test the theory at all.

I think the thing that makes most physicians in this state nervous is exactly what you said, is not knowing what somebody has and being asked to make decisions over the phone without seeing the exam, without seeing the patients, without seeing the data. That's the bigger risk for all of us when we

take that phone call.

For me, I'm lucky because I can say, well, send me the images, send me the data, send me the lab result. Let me take a look at it, and I'll get back to you because the default that most of us have in an environment where we're fearful of malpractice is we just say, send them down.

COMMISSIONER HARRELL: Just a follow up with your comment. I'm probably stating of the obvious, but nevertheless, I think I need to and that's that, I mean, the low-hanging fruit will be grabbed. The individual patient case that we're going to make a financial impact on will be fairly easy to get to fairly quickly, but if we go back to yesterday's conversation about the pursuit of health, even though the financial large numbers will fall off fairly rapidly with the use of telehealth and the more global sense, what you're really going to be doing is setting up the ability to impact health. That becomes a public health issue, and I think that's still a powerful motivator to move forward. And changing the psyche to get there is a different story, but I think, if the State moves forward, that's the message that needs to be out there is, hey, we're going to recognize the significant financial windfall early, but look down the road at the public health implications of this, even when the dollars don't remain as large.

DR. KOKESH: And I think we learned a great lesson about

the public health implication when we were so -- remember when we were so fearful about bird flu and then, before that, SARS? Well, we dodged the bullet on that one, but you know, a robust telehealth system hadn't been in place statewide. And it was, to some degree, but if we really had a robust system, then that would have helped tremendously with that problem. For example, we could have screened people without actually bringing them into our emergency rooms and infecting populations. I mean, when we were thinking through how we were going to deal with that, I think all of us, at the time, said, boy, I sure wish we would have had this videoconferencing system in place; it would this easier to manage.

COMMISSIONER CAMPBELL: Two things. As a rural hospital administrator for a lot of years, it used to drive me crazy -- you talk about the telephone call to the specialist in Anchorage. You'd have someone in the ER or in the hospital, and the local medical doc would call for a consult. Well, you could just visualize the guy, the consultation on the other end is going to say, oops, I can't look at this patient, and invariably, you're going to get that person either in ambulance or an airplane. And it used to drive me crazy trying to overcome the local perception that the local medical doc didn't know what he was doing and trying to convince a community that this was appropriate medicine, and maybe this

would be my saving grace in this day and age, if you had a visual, but that's just an experience thing.

It strikes me that Wes is right that the mandate from the Legislature is impossible, but we do have a major -- a couple of major perpetures (ph) in this thing, and one of them is Medicaid. And there are regs that could be promulgated, I suspect, that would maybe move this football down the line a ways. I don't have any words for that, but the wordsmiths can take care of that. But that strikes me as a way of maybe moving this ball, if someone in the Legislature might encourage the Administration to do that. So anyway, that's just a thought.

CHAIR HURLBURT: Stewart, did you have another comment?

DR. FERGUSON: Well, I was just going to follow up on both those comments. So about six years ago, the Centers for Disease Control actually approached us and said they wanted to look at a tool that they could put into all 50 states where people could actually capture information and send it, in case there was a major outbreak across the United States, and it approached our program and said, we heard you have some software we could use. And so we talked to the CDC about using it. It didn't go anywhere, but the idea is that it's a national issue, and I think what John is suggesting is we actually have that in Alaska, and you know, how we leverage that and make it ready and use it for those kinds of issues is

a good conversation to have.

And then just as a follow through on the use of health aides with telehealth, one of the things that we learned years ago was that -- well, it was a concern. We were worried the older health aides would not use the technology, and what we discovered is that we have such a high turnover with providers in this state that we have a cadre of very experienced folks in the village, health aides that have been there 20-30 years, and now they have a fresh young doctor they have to communicate with, and it's kind of that problem of they know what they're seeing in the village, but sometimes, you just have to convince the doctor what they're actually seeing is real.

So you know, one of the benefits of funding reimbursement and building infrastructure is you build a communication technology so we alleviate some of those issues of people that come, go, and leave the state, and you actually are -- people can communicate and share images and convince people of the right path for the patient. So it's one of those unintended consequences of funding a statewide telehealth system.

DR. KOKESH: And with the regard to the private insurers, even if it's not possible to mandate it, I think, if you incentivize the system, open it up to the private community, it would probably be untenable for a private insurer to offer a product in the state that doesn't cover telehealth, that

won't cover how 10% of the care is delivered. So I think that would probably take care of itself over time.

CHAIR HURLBURT: Thank you very much. This was exciting and interesting. We appreciate your coming. You opened all our eyes a little more, and I guess I would just maybe close by referring back to one of your slides that showed your funding at about two-thirds of what we pay. Otherwise, we know that, in Ontario, they're probably funded at about 60%. Somehow, they're managing to do it with a lot less money, and in Ontario, at least, they're living longer, and they're babies are dying less than ours are. So if they can figure it, we ought to be able to here with a lot more money. Thank you so much.

DR. KOKESH: Thank you for having us.

CHAIR HURLBURT: If our other -- the next four panelists could come up to the table, and we're going to hear now about some current telehealth programs, including the eICU that Colonel Harrell mentioned with some things that we're doing here in the state.

CHAIR HURLBURT: We're going to hear about the Providence Alaska Medical Center eICU program first. Dr. Javid Kamali is the eICU Medical Director, and are you Cecilee? Oh, you are Cecilee Ruesch, who is the eICU Clinical Manager. So welcome. If you folks could go ahead first, please?

DR. KAMALI: Good morning, everyone. Thank you very much

for the opportunity to give us a chance to present our programs, and I want to emphasize (indiscernible - voice lowered) of being with Dr. Ferguson and Dr. Kokesh about their project. Dr. Ferguson is my personal role model for what he has done in the state and in the nation. He is nationally and internationally recognized for what he is doing, and we're going in his footsteps, several years later, with our tele-ICU project.

I'm here with Cecilee Ruesch, our Clinical Manager, and of course, Christie Artuso is presenting her own project about telestroke.

Deb asked me to be very specific with the agenda in the ten minutes. I pretty much tried to describe the program very briefly, and only one slide about the evidence of improving patient outcome, what we've done over the last three-and-a-half years, and I think you're very interested to know some of the barriers and challenges we have, both in the past and also in our future paths to expand the program and where we're going from here.

UNIDENTIFIED COMMISSIONER: Can you introduce yourself, please?

DR. KAMALI: Oh, Javid Kamali. I'm the Medical Director of the eICU program.

Dr. Ferguson and Dr. Kokesh talked about a large population of the patients, and I'm not trying to say that,

you know, the ICU patients, the critically ill patients are more important. So are a slice of that big population, but I try to make my case why we should care about this patient population. Obviously, they are very vulnerable.

By definition, critically ill patients are patients who have, at least, one organ system failure, like patients who have failed to breathe on their own. They're required to be intubated, be placed on a mechanical ventilation or they're so sick that they need to be observed. Any small change could result in cardiopulmonary arrest because they have very limited reserves, and these patients usually end up in the ICU, which is a very complex environment, a high concentration of skilled nurses, physicians, respiratory therapists, technical equipment, et cetera, which makes it very prone to mistakes, and every small mistake -- studies have shown that, on any given day, we make two relevant mistakes on every ICU patient. So it is important to focus on this patient population.

And generally, the trend is, if something goes wrong, it's a slow trend, and if we, first, screen for that, second, identify that, and third, intervene, we can prevent a major disaster. It's unlike the outpatients, who, you know, I see them. I'm also a pulmonologist. I see them in my clinic. I do an intervention. I say, come back in three months. In the ICU, I constantly observe the patients, intervene, and

reassess them, and I either continue or back off or do more.

Also even now, even though we have become very good with hospice and end-of-life issues, a third of all the deaths happen in the ICUs, and there are different statistics that all the old comers that come to the ICU, 10% of them, regardless of what we do, die because of the severity of their disease.

The next point is really important that, unlike a lot of other industries or systems, such as aviation, you know, engineers, we tolerate variability in our care delivery and that's sad, but it's something given, like to give you an example, if something goes wrong and I've been covering two hospitals, I say, what do you want me to do? I can't clone myself. I was taking care of this patient at this hospital. So this is kind of accepted that we do not deliver the same care to different patients at any given time or we have limited resources.

Up to the time when I came to the state of Alaska in 2007, we had only five or six pulmonologists. The number has changed, but the waiting list was up to three months for the patients, and the ICU was covered by a pulmonologist who saw patients until 5:00 p.m. and had to have dinner with his family, and if the critically ill patients ended up at 5:30 p.m., he or she had to wait for the pulmonologist to come back two-three hours later, and a lot of things can happen. So the

variability in care delivery is something major that, unfortunately, we tolerate in medicine unlike any other industry. I'm pretty sure you've had experiences, like me, that the plane ends up at the airport for several hours because one small piece of equipment is missing, and we tolerate that because it's about safety. Why should we tolerate that in medicine? And that's the point that we're changing our mind set, our thinking.

And of course, ICU is very, very expensive. I invite you to come and see, like, some of our patients' infusions and pumps and ventilators and oscillators and dialysis machines, and of course, the staffing is a major, major cost for this not-so-big proportion of the patients.

And the next two are about Alaska. We have very, very challenging logistical and geographical resources. The number of physicians, the number of respiratory therapists, nurses has been a challenge recruiting them and also retaining them, what Dr. Ferguson already mentioned. And of course, we're the largest state in the U.S., very, very thinly stretched over the huge geographical resource, and of course, the connection, which is, of course, mainly through air.

And of course, the high costs of transfers. I mean, Cecilee was telling me the other day that it costs $300 to transfer them across the street to a different hospital as opposed to us, which is thousands of dollars.

Very briefly about our project. The Providence eICU uses two-way video to connect with the users in our hospital, and also now we have three what we call outreach hospitals. We have 24/7 critical care support. The nursing staff is 24 hours per day. It's ongoing, and the physicians are mainly at night. It's only at night from 9:00 p.m. to 7:00 a.m., and the reason being that these are the times when, usually, the bedside physician is not available, and during the day, they're usually available, and bad things can happen in the ICU patients. Their critical illness doesn't go away at night.

And we monitor their vitals, labs, and medications. We review them, and we make sure that the critical care practices are applied in a standard fashion to every patient. And of course, there are highly sophisticated software programs that monitor the trends and warn us if we tend to miss those.

The sites that we're currently covering and serving -- of course, we started in January of 2009 with our own hospital at Providence, which is a 28-bed acute care facility. It's a Level I trauma, highly sophisticated. We have pretty much every service, except bad burns, and of course, no transplant, but everything else is provided. Right, a 28-bed, ICU bed.

And in May 2010, Kodiak Island, which is the second largest island in the nation, joined us. The main issue with them is that, during the transfers, because of the weather, a

lot of times, their patients end up, you know, being stuck because of the fog or bad weather. So it makes sense to have connection with them, not only for that but also for their own patients, for the limited resources.

And of course, our first out of state institution was Seaside Medical Center in Seaside, Oregon that joined us in May 2011, and we've had pretty good success with them with one mobile cart.

And Dr. Urata is here. In February of 2012, we were very excited that the first non-Providence center joined us, and with that, the last capital in the nation that did not have access to intensive is -- that service was provided, and as of now, they have two beds that are flexible. The patients can move around in their unit, but at any given time, we can see two patients. In fact, we were covering a lot of them last night when I was on.

I'm not going to go into technology as much. I'd rather spend more time about the big picture, but this is mobile cart, which has the basic, you know, two-way video with a computer attached to that. We can quickly go through those slides. Next, please.

And this is a COR. Again for clinician's standpoint, it's like a dream come true that everything is in one area, all the information I want, the notes, the x-rays, the communication tools, and I can see the patients and that's so

important. Dr. Urata can confirm that. Putting my eyes on a patient with respiratory failure with breathing problems and telling this patient is toxic, this patient needs to go on a ventilator, it's so precious as opposed to, previously when I was in a different hospital or maybe at home getting a phone call about a patient with bad breathing, I could only depend on whoever it was on the other side of the phone telling me what's going on, but now just looking at the patient, it's priceless.

And this is one of the screens from this service that we have, which has pretty -- very user-friendly information from different, you know, trends of the vital signs, all the lab information, fluid coming in and out, et cetera.

And the Smart Alerts are something that I told you about. These are software programs that they have incorporated in the system that alarm us with something, some physiologic parameter going completely out of whack, and we need to address that and put it into context, and some of the times -- I mean, most of the times, they're false positives, but a lot of times, they are issues that need to be addressed right away and prevent a disaster.

Just one slide about the results, and again, I can expand to that, if necessary. I think we care about death and leaving the ICU alive. Our hospital mortality was 0.48 with one being the expected mortality and survival, and 0.48 is

extremely good. In fact, I can say, among all those 30 hospitals that I have worked or trained in my career, this is probably the best. This is where I want to end up, if myself or my loved one is critically ill.

And we've had improvement in compliance with some standards of care, like ventilator days, ventilator bundles, which have also been translated in better outcomes. So if you prove that you follow the protocols more closely, for instance, the ventilator parameter from 86% to 98%, close to 100%, we can say that this is one of the reasons that this has happened.

And by the way, as much as I want to, I cannot claim credit for that improvement in mortality just by the eICU because a lot of interventions have been done at the same time in every ICU and that's a difficult thing to attribute, but again, I'm pretty sure part of it is from the interventions that we've done through having a second layer of eyes being on patients.

Glucose control is something that is part of the quality measurement in every hospital.

Reduction in transfers are big. To give you an example, in the first year, we prevented 17 transfers from Kodiak Island, which imagine every one of them is about $20,000. So with two transfer preventions, they can pay for the cost of their annual service for that cart, and the other 15 is a

bonus. And these are things that, I think, Dr. Ferguson also briefly mentioned, that these are value of this investment. They're a cost that we can write in black numbers and offset the red numbers, but these are things that are hard to prove. Like something like retention of the physicians or nurses, they are thousands of dollars, and the quality of, you know, recruiting somebody we don't know, and until they become more and more experienced, these are things that need to be put into the equation that are hard to measure with a number.

And of course, I did mention compliance with mandatory regulations, such as restraints. And of course, the support that the nurses and new nurses and new physicians get through the eICU is priceless. I mean, we've been able to retain our graduates from the school, which is a tremendous help to staff our ICU. We depend less and less on travelers, which, of course, need a lot of time to get used to the system. Of course, they are much more expensive than the full-time staff.

Future directions. We have a lot of goals, but I think I'll focus on one, that we have the tools and we have the manpower to staff our ICU, and we would like to offer standard 21st Century critical care to the rest of the state and possibly beyond, but there is a lot of room to improve the standardization and making sure that there is less variability in the care delivery, specifically to critically ill patients both at Providence, and of course, non-Providence facilities,

which is a major proportion of the rest of the state.

And challenges are tremendous. I mean, the beginning -- of course, I mean, cost is a major challenge. These are not cheap investments, and we're very, you know privileged that Providence administration decided to do that.

And of course, one of the major things is the change in the culture, and of course, being a clinician, we know how resistant we are to losing control, but once we get used to that, we realize that it's not losing control. It's just sharing, sharing ideas, and communicating, and collaborating rather than replacing each other.

The reimbursement model has already been mentioned. I can only emphasize on that, that something that has been a challenge is our expensive programs. The maintenance is actually very, very expensive. So if we could find some tools to support these programs, we can expand. We can decrease our costs, so more and more (indiscernible - voice lowered) programs in the state can join us.

And one of the other challenges is that there are different systems, and of course, I mean, the Native system has a very sophisticated, very efficient way. There are so many vendors for tele-ICU that we are using, and some hospitals are not compatible and have to invest some upgrades or even different systems. So that has a been a challenge, and of course, I mean, Dr. Urata can witness that, that to

connect with Juneau, we have to go through a lot of challenges.

And of course, technology grows fast, and they want us to spend for their new technology and that's another challenge that, sometimes, it's a little bit too fast for us to keep up.

This is one slide that I got from just the recent presentation in May at the American Thoracic Society, which is the largest critical care meeting and pulmonary meeting in the world, and they presented a -- very non-vendor dependent, by the way; it was not from the vendors -- how fast it is growing and that curve, I don't think it will plateau any time soon. I can only imagine that it would just keep going up, and I'm pretty sure, in the next five, ten, 15 years, at least, half of the ICUs are covered with that, which is a tremendous improvement.

So as of now -- it's so small; I can't even see it. I think as of 2012, about 7,000 beds, which is about 15% of all the beds in the United States, are being covered or supplemented to the ICU. I think there is a second part that will be after this. Yeah.

This is a comment from an independent panel that was supposed to look at telemedicine data and make recommendations for or against it, and this is what they came up with, that the question is no longer if we should use telehealth information, in general, telehealth/tele-ICU in care of the

patients, but how we use it. In other words, it's not a one-size-fits-all. There are institutions. There are patients that benefit more than the others, but tele-ICU is something that a lot of experts in that field agree that it should be because the sicker the patients, the more I intervene, the more impact I can make.

And this is the last slide. Tele-ICU is already a part of our care delivery. I think -- I mean, I work both sides of the camera. I work at the bedside. I work in the tele-ICU. After three-and-a-half years, we have become one. It's not you are the bedside intensivist; I am the ICU guy. We have become one. They admit the patient. They sign out to me, and I continue managing the patients while they go and meet another patient, and we already have this tool in our state.

It has shown, in our institution, that it improves survival and better compliance with protocols and reduction in transfers, and I'm highlighting only three of the many that we can point to.

And this is what I talked about. Again, I tried to go away from the technology, the details, but talk about the way we practice medicine and the way we are redesigning, rethinking delivery of 21st Century critical care to our patients and that's the key word, that there shouldn't be any discrepancy between a patient here in Anchorage in the ICU at Providence and a patient in Bethel or a patient in Fairbanks.

They should all get the same care. Why shouldn't they? We have the tools. We have the manpower. We just need to connect.

And this is something that Dr. Parnabus (ph), who emphasizes the words "the delivery of care," that -- with this, we hope to reduce and better eliminate the variability and care delivery by providing the standard of critical care to every single patient everyday and that's the key word. I think, with that, I end my.....

CHAIR HURLBURT: Thank you very much. I think we may have time for maybe just two questions because we do have three other presenters. So Pat?

COMMISSIONER BRANCO: Thank you very much for your presentation. Two really pretty straightforward questions. First, what is the size of -- or the number of ICU monitored beds that one intensivist or pulmonologist can handle?

DR. KAMALI: There is no study for that, but generally, you know, we work in collaboration with the nurses, and they nurses, they say, between 30 to 50 patients, the physicians up to 100 because, again, we're not replacing the bedside physicians. We monitor them and intervene as needed, and sometimes, we have to ask them to come back to the bedside, but about 90% of the time, we can manage them.

COMMISSIONER BRANCO: And that's the second-half of my question is, in Ketchikan, there is a range of comfort with

managing ICU patients. The internists, who have many years' experience, are very comfortable and don't tend to cede much of the care of their patients to others, where others may not, maybe new physicians in practice now. So is there a range of support options and opportunities?

DR. KAMALI: There is. Do you want to answer that?

MS. RUESCH: So I think it's really important. When we go into a new institution, we work with them to find out what their comfort level is. So you know, what patients are kept at Kodiak is different than what patients are kept at Bartlett.

COMMISSIONER URATA: Just one comment. It's worked well in Juneau, and particularly for some of us who are getting older, where we used to be able to take care of a patient for four or five days at night, with each decade, I think I lose a day. And so now, I can only stay up one night a week. So it's really been helpful, and it may keep me in practice a little longer, and it's worked out pretty well for us in Juneau. We don't have data though because we just started.

DR. KAMALI: That goes along with the retention because, I mean, Dr. Urata goes to the clinic and sees the ICU patient, but if he is on the phone for his whole week, being on-call for the ICU, getting phone calls every five minutes, he will not stay here and that's one of the reasons we think -- I mean, he (indiscernible - voice lowered). That's one of the

reasons that we can help retain physicians and nurses here in the ICU.

CHAIR HURLBURT: Thank you. Larry? Last comment.

COMMISSIONER STINSON: Kind of like what we were talking about with the previous speakers, what kind of malpractice coverage do have if you get a call from Oregon and you're having to manage somebody there and you're in Anchorage? That's one.

And then, how do you bill for this? Do you bill as if you are at bedside or how is the reimbursement system worked out?

MS. RUESCH: So I'll talk about the reimbursement. So rather than -- there is no patient charge for this service. So the hospital that is receiving the service pays for an annual support fee that offsets the cost of our labor, and no patients are billed at this time for the service. The hospitals, as they retain patients and see improvements in care, are seeing the impact in their -- to pay for the service.

DR. KAMALI: And the malpractice -- again, we are all licensed also in Oregon. It was a challenge at the beginning because of the narcotic issue, which, apparently, there were some questions about that, but we did get the license. And again from the perspective of lawsuits, I think the families that they see -- somebody is available 24/7, and they can

communicate, they can ask questions, that they see you around at night with them, I think it actually makes the lawsuits much less likely, and so far, we haven't had any lawsuits. And when I go to the national meetings, they say very randomly, but it was not because of the eICU. It was that physician was on-call when they sued the bedside physician, but specifically, I'm not aware of any lawsuits in the last 12 years that eICU has been available.

CHAIR HURLBURT: Thank you all very much for the presentation and sharing what's going on here. Next, we're going to hear about -- it's another Providence program, the REACH Telestroke Program. Dr. Christie Artuso, who is the director of the program, is here, the Director of Providence Neuroscience Services. And I think, just for a guideline, probably we've got about 15 minutes each, including question time, for each of the next presentations. So thank you for coming, Dr. Artuso.

DR. ARTUSO: Absolutely. Thank you so much for having us. You might be asking yourself, why telestroke? Why did we select that particular area to look at for an acute care intervention? You've heard a lot about store and forward, which is an outstanding method for providing telehealth services, but there are needs for acute care and real-time videoconferencing, and I think you've heard that earlier.

Well, telestroke is internationally accepted. There is a

tremendous amount of evidence that supports its efficacy. They have compared a traditional live physician assessment of a patient with a telemedicine assessment throughout the world and found that there is no variability. They have actually looked at the complication rates with stroke patients and found that they are actually less with telemedicine, simply because you are able to connect that patient and a community provider with a higher level clinician with many more years of experience who is working collaboratively with your community partnership sites.

So that's one of the reasons we selected this as a program to test in Alaska and to see how it would be received. It certainly does improve access to those qualified professionals, and as you have heard earlier today, we have very few of those in this state. In fact, we only have one vascular enterologist in the entire state of Alaska, and he joined our program in 2008. Prior to that, we had none. And so if every stroke patient could be seen by a vascular enterologist or a stroke specialist at the point of entry into the health care system, the evidence, nationally and internationally, says that their outcomes will improve.

And just to share a little bit about the costs of those outcomes, in 2011, it was estimated that $90 billion per year is spent on stroke alone for their hospitalization, their rehabilitation, and their lost wages and earnings. So that is

a tremendous number of health care dollars that are spent on one entity, and we're only seeing an increase. Even though, statistically, you'll read some reports that will say stroke is decreasing significantly in the United States, there was a different measurement involved. So it's really not accurate from a research perspective.

Stroke is still a significant health care concern. We have an increase in obesity, increase in diabetes, and these are all elements that contribute to stroke. We know that this type of medicine provides an improved quality to the bedside because you are using a collaborative approach as opposed to one physician or one mid-level practitioner.

We make recommendations for care. We work with the physician at the bedside. We do not take over the care of that patient. We're working with them collaboratively and the families. The patients are involved. The patients can see the physician. They can have a conversation with them. So can the families, and it's been very, very well-received at the point of delivery.

And it's also education and training. Many of our collaborative partners in the communities that we serve have really developed a tremendous knowledge base for identifying stroke patients. They are not the classic patients that you've seen in your medical textbooks. In Alaska, they're much younger. Often times, they don't look like a traditional

stroke patient. So we've seen their understanding and knowledge improve so much that we're making a better assessment at the point of contact.

So this is a provider-to-patient type of program as opposed to provider-to-provider, but we do say that we're collaborative as well. So we have two methods, but we are really treating the patient. We're looking at the patient and having a conversation, doing a physical examination with a practitioner at the bedside.

Just to give you a little history of our program, we became an advanced primary stroke center in 2008. It was actually in around May. And then we were able to implement this program fully in May of 2009. So between 2008 and 2009, we evaluated the available technology. We looked at the infrastructure in the state of Alaska. We identified bandwidth opportunities, and we selected a program that allowed us to use the Internet with secure trafficking tunnels. So all of our video and all of our data is protected and would also allow us to see those images at the point of contact. So we can see the images of the patients in Bartlett. We can see the patient. We do a physical examination with the clinician's help at the bedside, and we have collaborative conversations with the providers and make a treatment decision. We implemented in five spokes between that May of 2008 and January of 2009.

The technology platform -- and I won't go into it in detail -- we chose is, basically, a telemedicine cart. It uses a sophisticated camera. It is the REACH Health Solution from Augusta, Georgia that was developed by a neurologist. It's a good solution. It's worked very well for us.

Today, four years later, there is a lot more technology to look at, and we're currently evaluating different systems, and a lot of reasons for that. We're looking at the technology needs, the infrastructure in Alaska, which is a tremendous concern, for that live, real-time video that works each and every time. You've heard it before. That is so important for our providers.

Right now, our technology is supported with the vendor and the partners here at Providence and all of our IT infrastructure is, of course, unreimbursed. So we're providing that support from our end with no reimbursement.

We are located currently in five collaborative partner sites. Bartlett Regional Hospital in Juneau was our very first, and by far, I have to say is one of the most successful sites. They are an awesome set of practitioners and have really embraced this service and truly improved the care to the community simply through working collaboratively. I can tell you that we honestly have decreased our transportation costs from Bartlett for stroke patients by about 90% and that is because only about 10% of the patients are actually

transported to Anchorage. Historically, 100% of those patients would have been transported either to Seattle or Anchorage, and Dr. Urata is agreeing with me on that.

And the reality is because they had only one neurologist in the entire Panhandle who could not be available 24/7. And so rather than making, you know, a challenging treatment decision with no backup, they had to transport the patient. The majority of those patients stay there, and I anticipate even more will with the eICU in place right now because we can not only treat the patient acutely, but we can provide that ongoing support for that higher level of care.

So here is a great example of how a partnership in two technology platforms has allowed us to help communities improve the care at the bedside with ongoing support and collaborative practice.

We do have this system set up in three critical access hospitals, Kodiak, Valdez, and Seward, all Providence partners. It's not used as extensively there because of the volumes of patients they treated. We knew that we would see two or three patients a year in those sites, but it is present, and we do see those patients.

And then down on the Kenai Peninsula, we have the capability at Central Peninsula Hospital as well. So we can see stroke patients there and make better treatment decisions and also determine who is going to be transported to

Anchorage. And I think the important thing to consider is that we're only treating strokes with this particular technology right now, but we envision a larger number of patients that would be certainly benefitted by using this technology to treat them at the point of contact with the health care system. Next slide, please.

So this is just a graphic that shows you where we're located, and the push pins are sites that we hope to eventually put an acute care videoconferencing system in. One would be Fairbanks, Cordova, which is a site we're currently working with, and then down in Homer, they've voiced a lot of interest. Certainly, the infrastructure and the costs, the lack of reimbursement are all factors in determining how quickly we can make that happen.

So some of the implications we've experienced, certainly, are the impact on nursing and medical practice. Just how does this impact how we deliver care? It's very different. And as Cecilee stated, we go into these partner facilities and say, what is it that we can do to support your care in the community?

It also might change what we expect from the health care system. What if every person in every city of the United States got up every morning saying, I have a need, how can I contact my specialist, and the first thought was, pick up something involving teleconferencing or videoconferencing. We

pick up our phone to contact our neighbor. What if the health care system became, how do I contact the person I need to support my care? And so it's really driving and changing the industry.

Also changing the communities perspectives, expecting that our community is entitled to the same level of care. We shouldn't have to fly in a learjet to access care. And I will share another perspective from a community. When they're put in that learjet with that phenomenal critical care transport team at a tremendous number of health care dollars, they expect miracles on the other end. We haven't seen those patients 99% of the time. And so many times, most times, we can't perform the miracles. So you have communities that are gravely disappointed in the quality of health care saying, what good did it do? And then they get the bill.

And so the reality is, by seeing that patient, making those treatment care decisions and only transporting the ones that we can do something appropriate for, we're improving the health of communities. We're improving the outcomes based on better care, but we're also improving their perceptions on what a truly robust health care system needs to do for the people they serve.

There is also a change in the provider, nurse, and patient relationship. Our patients have received this very well. It's actually fun. They can see on the camera. They

have conversations with us, and most of them have said -- in fact, I've never heard anyone not say this -- it was as if they were standing next to my bed. They just forget there is a camera and a video in front of them. So they do feel that connectivity.

Challenging from an infrastructure perspective, bandwidth, latency. That's very uncomfortable, and we need to improve it, and we have technology that can. It's expensive, and there is absolutely no participation, as far as reimbursement goes, for that technology. Next slide, please.

Outcomes? We have implemented successfully in five locations. We hope to implement in, at least, three more and expand these services to treating TBI in the acute phase as well as we're looking at a sleep medicine clinic application, which will also be live video, which will decrease the need for patients to commute from different locations.

Appropriate referrals. We want to get the patients that need a higher level of care here in Anchorage. We want them referred to us, but we don't want the patients sent to Anchorage who we can't do anything for. That is a waste of health care resources, and it's an area that we have to address. So it does decrease unnecessary transportation.

We've seen an improvement in thrombolytic care, and I know, Dr. Harrell, you asked before about outcomes. It's going to be challenging in Alaska to measure those outcomes

over a short period of time because of the volumes of patients that we serve, but I can tell you that, in Georgia, a Medical College of Georgia program, after 1,000 patients, their incidence of intracerebral hemorrhage was 2.7%. The national average and the average from the research is 6.9%. So what they have demonstrated, clearly, is a decrease in the amount of complications and an improvement in outcomes. We've seen no unexpected hemorrhages in our patients.

Now when I say that, there are patients that we treat that we will tell a family there is a good chance there is going to be a complication, and I will tell you that our physicians are right almost 100% of the time when they say that because they know, based on the patient's presentation, what the risks are.

My Medical Director, who manages this particular aspect of the program and sees many of the patients, has treated over 10,000 stroke patients. He is awesome, and we are so fortunate to have him here in Alaska. But we don't see any that we don't anticipate. We've had some excellent outcomes, but again when you're only treating, you know, ten or 15 patients a year statewide, it's very difficult to say because one outcome is going to be very, very significant from a percentage standpoint.

What I can tell you is that, prior to this program, we treated almost no patients in the state of Alaska with

thrombolytics, which is the national benchmark for care. Today, we're at 4.7% of all ischemic stroke patients. That is higher than the national average, with good outcomes. And so we're pleased with that percentage rate, and we believe, if we can connect more patients at the right time with a highly prepared clinician, that we'll see those outcomes continue to improve, and over time, we'll be able to measure that.

We certainly have seen an improvement in the identification of stroke patients at the hospitals, and we believe that's through education. They know what they're looking at. They look at their results. They know when to call, and they really don't make unnecessary calls. In fact, we tell them, call us more. There is no charge to the organization for making those calls, every single one of them. It's only the consultation fee, which we all know is reimbursed a little bit lower.

One of the program challenges is providing sustainable and qualified physician coverage. There is really no incentive to do this. They reimburse at a very low rate. In fact, most of them don't even bother to put the paperwork together because of the reimbursements. It's also asking them to cover the entire state of Alaska and saying do it because it's the right thing to do and because you're a good person. Sometimes that's successful. Other times, not so much.

Adding neurosurgery coverage is something we'd really

like to do. All of the neurosurgeons in the state are, essentially, located in Anchorage. And so how can you provide access to those services to patients in the periphery at the time of injury or their need? Certainly, many of their evaluations can be done via telemedicine with access to images and that's something that's been challenging, but we'd like to be able to help that improve a little bit.

Levels of reimbursement. We've talked about connectivity is huge in this state, and we're all carrying little phones in our pockets that we dearly love. And then there are the iPads. But Alaska still has the same bandwidth it did four years ago, and I will tell you that those devices have impacted our ability to connect and maintain connections, upload images, and to sustain that connectivity. A dedicated infrastructure for health care would be ideal where we would have a separate bandwidth for health care use only because we need that connectivity. We can't afford to be cut down. We can't afford to go down. The patients can't afford it.

Changing technology, oh my. How fast is it? By the time we invest a half-a-million dollars in a series of technology, get it to Alaska, install it, and educate everyone, there is something new that probably works better and with better connectivity. And how do you sell that to a CFO? She runs when she sees me coming.

Trust, and it was mentioned before. We're not replacing

physicians in the communities. They do a phenomenal job. We want to work together to help them meet the needs of their patients with highly complex conditions and help validate some of the decisions that they're already making and letting them know that we're there to support their care, not to take their patients from them. Next slide, please.

Future strategies. We have a group that has been meeting over the past nine months talking about the telehealth and telemedicine as a collaborative in the state of Alaska, what are the needs of the communities, and just really looking at ideas.

Alaska region, at Providence, has an initiative where we're putting people together saying, how can we meet the needs of the communities that we serve?

Providence Health Systems from a five statewide collaborative has put together a team to look at, how can we support all the patients we serve in all five states and all the rural communities?

And then certainly, we're looking at evaluation of the systems that are being used and that's technology, the reimbursement, the infrastructure that's required to support it, the resources, and the community needs as a part of that program. Final slide, please.

So in summary, telemedicine will be or is a growing strategy for the delivery of health care throughout the United

States and global communities. Through technology, access to specialized and acute care services will improve, and the overall health of communities will improve because they will have access to those services, and the way we deliver health care will change. Thank you.

CHAIR HURLBURT: Thank you, Dr. Artuso. Just a quick comment or two? Keith?

COMMISSIONER CAMPBELL: You talked about dedicated bandwidth for medicine only. Would that require separate networks from all around the state or is it -- could it be piggybacked somewhere?

DR. ARTUSO: Well, I'm not an IT person, and they would be the first one to tell you that I'm not, however, not necessarily. There are ways to separate bandwidths at the point of contact, and I'm learning more about that everyday. Again, I'm a health care provider as opposed to an IT person, but we only have, right now, two big pipes coming up to Alaska. If one of them goes down, we're down. But the reality is that, if you can separate it at the point that it comes out of those pipes, even at the point of contact, there are ways to separate it out, potentially boosting, using compression software. So there are new technology platforms that may allow us to do that without putting a whole new network in, but I think you need some really good IT folks at the table to discuss it, and several of us have said, why

isn't -- why aren't Apple and Microsoft sitting at the table? This are what the needs are; let's make it happen.

COMMISSIONER CAMPBELL: You do realize that Ted Stevens got into trouble (indiscernible - simultaneous speaking).

DR. ARTUSO: Yeah. Sorry.

CHAIR HURLBURT: Last comment.

COMMISSIONER HARRELL: Just a comment, Keith. Although, undoubtedly, there are pipe issues here, bandwidth issues here in Alaska, a lot of times this boils down to server construction in terms of how to push the data through. So using, again, DOD experience, when we look into it, usually the pipe is big enough. Our problems are router and server construction and how the data is being pushed through the pipe that actually ends up affecting the ability to do those things.

CHAIR HURLBURT: Thank you all very much again. That was wonderful. The next thing that we have on the agenda is the Alaska Federal Health Care Partnership's Home Telehealth Monitoring Program. Major McIntosh is here, who is the Deputy Director of the program with the Alaska Federal Health Care Partnership. Thank you, Major McIntosh. Please go ahead.

MAJ. MCINTOSH: Thank you, sir. Good morning. I've just taken over, in addition to the Deputy Director position, the program management of the Telehealth Monitoring Program. So that's only -- actually, today is my second week being in the

position.

So I do have a short video that will kind of explain in great detail your program and how it's benefitted the State of Alaska, if you could. It's about maybe five minutes.

(Pause)

COMMISSIONER ERICKSON: We might not have the video. I don't think it's going to work. We didn't get to test this one before the meeting, so would it be okay if we just went on to your slides, Major McIntosh?

MAJ. MCINTOSH: Sure.

COMMISSIONER ERICKSON: It appears to just be looking at a picture of it, and I'm not smart enough to.....

(Pause)

MAJ. MCINTOSH: It's the Windows Media Player on the right.

COMMISSIONER ERICKSON: Yeah. That's where we were. Sorry about that. That's okay. We need to test these things in advance. We'll just do the.....

MAJ. MCINTOSH: All right. Next slide, please. You may have heard of some our previous telehealth initiatives, the AFHCAN cart, the teleradiology, and AHERN (ph). Our current initiative is the Home Telehealth Monitoring program, and what we say, you know, in our program is that what gets monitored gets managed. What gets managed, of course, helps to reduce cost of care. It also helps to avoid acute episodes, and all

of this is done through coordinated care through a 24/7 call center with real-time intervention, in the case of a patient's vitals are out of parameters. The parameters, of course, are established by the providers at the various health care clinics.

Currently, we have 356 federal beneficiaries using the HTM program to manage their chronic diseases. The program was voted the "Best Rural Health Program in the Nation for 2011" by the National Rural Health Association.

Currently, we are not -- you know, there is no refunding mechanism here. And so, of course, you know, funding challenges do kind of create some very difficult challenges for us for limiting the program, and of course, in the future, you know, there is the possibility that, you know, the program may go away. So what we're looking into are a couple different funding resources, possibly, you know, going through, you know, Medicaid and coding for helping to reimburse for the system, you know, for the program.

These are some of the communities that we're in. Currently, we're in 65 communities. We are branching out. Right now, as of last night, we've got projected up to -- as I mentioned previously, we've got 356 patients currently on the system, and by about the 20th of July, we should be about 402. Eventually, we would like to, you know, if we can get this program to sustainment, get up to, like, 500 and eventually

1,500, and you know, kind of pass it on to some of the other health care agencies and that's part of what we do with our initiatives is we grow them, mature them, and then, you know, get them to where they're sustainable and then pass them on.

Now of course, being you didn't get a chance to see the video, a while back, we had three patients that they went back and they looked at all their cost data, and you know, how much they've been Medivac'd, at their hospital stays, and things like that for the year prior to coming on the program. They also monitored them for the year after they came on the program.

During that time, it was determined that, within just three patients, it was a cost savings and cost avoidance of approximately $630,000. One of the patients that had been part of that program, he just passed away this past fall, but he basically -- you know, from the time coming onto the program, he was able to live at home, which is what he wanted to do, to be able to, you know, be there to be with his grandchildren and to do his fishing. And he wanted to stay out of the hospitals. He wanted to stay out of the Medivac system and everything. So he was able to do that for a good four years after coming onto the program. And so you know, that's one of the benefits, in addition to the cost avoidance, and you know, is, basically, you know, providing our patients with, you know, a chance to stay at home, be with the ones

that they -- you know -- the.....

COMMISSIONER BRANCO: I'm presuming that the video was going to highlight some of the components of the pieces that are actually -- I can make out a blood pressure cuff. I can make out some point of care testing, probably blood sugar. What are some of the components that allow these folks to stay at home?

MAJ. MCINTOSH: Well, we did have, like, the white scales, the blood pressure, the (indiscernible - voice lowered), glucometers. So I mean, we've got, you know, different modalities that, you know, they are able to, you know, to monitor, and what they do is they go ahead, and each day, they take their vitals. They hit the send button. It goes to our call center, and like I said, if it's out of tolerance of the parameters established by the providers, then what it does is it sends an alarm. Someone at the call center will call to that patient and ask them to go ahead and redo their vitals. If they get the same kind of reading again, then whatever protocol is established by the provider, that's what will happen next. So if it's a matter of contacting the provider, himself, or you know, depending on what the episode is, they may go ahead, and you know, start the -- you know, send them to the clinic or Medivac procedures.

COMMISSIONER BRANCO: One more quick follow-up. You've probably heard we have winter here in Alaska. This sounds

like an invaluable tool, especially for folks who are remote and monitoring their health care, and even the need to drive a few miles is extraordinarily challenging in some of our environments. Is that one of the added benefits of the program?

MAJ. MCINTOSH: It is. It does cut down on cost of travel, not just the Medivacs but also between, you know, the individual's home to the village and/or to the health clinic. I know, like this past winter when we had sent a team up to Nome and the surrounding areas, they actually got snowed in a few times. And so even the Medivac system, I mean, you know, you can't always fly. So if we can keep the patients at home, keep them monitored -- it also frees up appointment times for your less, you know, chronic patients, so you can, you know, keep them from becoming chronic patients.

COMMISSIONER HARRELL: So this is coming out of the Alaska Federal Health Care Partnership, and although the intent initially was rural, we've engaged in it in terms of your earlier commentary, Dr. Hurlburt, on the low-hanging fruit part.

From our perspective, this process allowed us to increase capacity. So we've taken our high utilizers, particularly our diabetics, enrolled them into this process, even though they're not rural, but we've seen measurable decreases in hemoglobin A1cs, and we've created capacity in our system

because they're not coming in. And those that are more complicated, we link this with the e-consult. So when one of our internists has a question regarding the home health monitoring data, they now link up with an endocrinologist, get the appropriate specialty consultation, and feed that back to the patient, all without the patient coming into the facility. So that moves us more towards that health piece again.

MAJ. MCINTOSH: Thank you, sir. Any other questions?

CHAIR HURLBURT: Thank you very much.

MAJ. MCINTOSH: Thank you, sir.

CHAIR HURLBURT: This is another good example of some exciting things going on right here in Alaska. The next presentation scheduled is the SEARHC TeleBehavioral Health Program. Melody Price-Yonts, are you on the phone?

(Pause)

COMMISSIONER ERICKSON: Melody, if you're on the phone, you needed to enter a one at the end of the four-digit code for us to be able to hear you. So what I'm going to suggest is that we actually take a break, and we'll see if we can get a hold of Melody. Take our break 15 minutes early. If we get a hold of Melody, we'll tie her in, and we'll be reconvening 15 minutes earlier than we would have otherwise. Otherwise, we have a large enough panel. I think we can take up the rest of the morning with that, and we did hear a little bit from Melody when she was with us at our last meeting about their

TeleBehavioral Health Program, and we've added Melissa Stone and a special guest from Oklahoma talking about telebehavioral health at the beginning of our next panel anyway. So we'll make sure we catch up on that.

CHAIR HURLBURT: Let's break and be back at 10:30.

10:13:43

(Off record)

(On record)

10:30:43

CHAIR HURLBURT: Melody Price-Yonts is on the line with us, and we'll take the next 15 minutes here. We want to hear about the SEARHC TeleBehavioral Health Program. So we'll hear that and then we'll move right into the first of the Reactor Panel with Melissa Stone, who is the Director of the Division of Behavioral Health here in the Department, and Chris Tarpley (ph), who is the Videoconference Engineer from Oklahoma Department of Mental Health and Substance Abuse. So we'll kind of look at that as complementing each part. So Melody, if you could go ahead and start, please? Again, thank you for being here online.

MS. PRICE-YONTS: Thank you. I really appreciate the invitation. Here with me, I also have Ed Sugai, who is the SEARHC TeleBehavioral Health Administer. So he is kind of here as our backup, my backup. And I think, Deborah, do you have the slides?

COMMISSIONER ERICKSON: Yes. I do. We're displaying them right now. We also have them -- for other folks online, we have them on our website.

MS. PRICE-YONTS: Wonderful. And I also provided just a fact sheet as a backup to the slides, so that you don't have to pack those around with you.

So the SEARHC TeleBehavioral Health is really quite a robust program. We are able to offer all of our psychiatry services to 11 communities throughout the region, and the first slide really shows some of the actual services that we're able to provide. It's just as if an individual that is sitting out in the community can access psychiatry level services, our psychologists, or any type of our specialized Master's level clinicians just to receive that direct patient care. You know, we can do the medication management, the screening, the diagnosis. We have used it for crisis intervention, with referrals. We also use it for training. The next slide, please.

So a little bit of a history. Here in SEARHC -- and this was before I came to SEARHC, but the TeleBehavioral Health Program was created with HRSA 330 monies as part of an expansion grant, just so that we could start reaching out to the communities that we service. You know, with SEARHC, we have -- SEARHC is a consortium of 18 communities throughout Southeast Alaska. And this map -- the next slide.

This map shows you the communities that we are currently engaged with in Southeast Alaska, where we're able to provide telebehavioral health services. There is an asterisk by Skagway because we've got the equipment. The T1 line has been run out there, and we're just problem-solving now. We've got to get the technology piece, work with ACS to finish up that process so that we can open up services in Skagway. But those are the communities, again, throughout Southeast Alaska. Next slide.

The goals of our TeleBehavioral Health Program, of course, are to increase access to behavioral health services, increase the HRSA Community Expertise, and this really helps to empower our local providers. In many of our communities, we have -- we'll have Master's level clinicians that are there on the ground in the larger community. In some of those smaller communities, we will have the paraprofessionals, the behavioral health aides that are in the smaller communities, and they really serve us as case managers to backup the psychiatrist and the clinical psychologist that's here in the Sitka community. And again as with the other telehealth programs, the TeleBehavioral Health Program does decrease costs. We do not -- behavioral health services under the contract funds -- the contract funds do not cover behavioral health. So if we need to get an individual into Sitka to receive services by a psychiatrist, our contract funds do not

cover the cost. Unless they're on Medicaid or have the funds to themselves, you know, SEARHC does not have the money to bring them in. So there is definitely an advantage there and a decrease in the costs.

We, again working with our community providers -- on the next slide, our second goal is to empower our community providers. We provide clinical supervision. We deal with the rounds. We do case conferences and peer review. We have really expanded with our monthly seminars and our other trainings, and we do other special programming as needed. A lot of that falls in the form of crisis management at this point. Again, these are -- the next slide.

These are some of the services that we do provide, the psychiatric services, the mental health and substance abuse consultation, our prevention services, and our counseling. And again, this really helps with the customers that we're servicing. They don't have to leave their home community, and the feedback that we hear is they like that. Some individuals in our smaller sites, especially, they don't want to travel. They don't like to travel. They don't want to get out of Kake or Angoon or maybe even Petersburg. They would rather stay at home and receive the services.

In some of our communities, especially when you look at a community the size of Kake, which is 450 population and on the decrease, we do have local behavioral health services there.

We do have our paraprofessionals there, but that person could be a neighbor. It could be an auntie. It could be an uncle. And the anonymity that -- the customer experience with the anonymity is huge. You know, they really appreciate being able to come in and talk to somebody on the TV screen, and once they're done with that session, they're done. They don't have to go back and see that individual in the community. So they really appreciate that. The next slide.

We talked a little bit about the increased access to services. Here within the past two years, we've had an increase in our telebehavioral health services by 50% in less than a year-and-a-half and that was actually one of our goals as little as two years ago and that absolutely speaks to the increased access to services. You know, I already talked a little bit about the hometown, the family home life is maintained, again enriching the customer service experience. The other issues as well or the other components, no unnecessary work absences and reduced travel risks.

If you go back and take a look at that map, one thing unique that all of you are aware of is that you cannot hop in your car and go from Juneau to Sitka or Kake to Juneau or Petersburg to Sitka, you know. You're either taking an airplane or you're taking a ferry, and in wintertime, that can be a little bit risky. And again, we're talking -- the next slide, please.

Here is our virtual community. Right now, our services -- the hub is Sitka. We're looking at expanding that, but I'll speak to that in a little bit, but right now, the hub for telebehavioral health with SEARHC is in Sitka, and those are the communities that we service.

And the last slide is our contact information, and a lot of that information that I shared with you is listed on the fact sheet as well.

Regarding the future direction for telebehavioral health, we have a couple areas that we'd really like to expand on here in the near future, and part of that is, of course, service-related. We want to really get more involved in our continuing care.

Here at SEARHC, we have two residential programs on the Sitka campus where we're sending individuals that go through residential treatment back to their community with limited support once they return to their communities, just in terms of AA or NA or ACOA or just any type of the sober support groups are very benefitted in some of the smaller communities.

We also want to really look at our veteran outreach program. You know, as we all know, our veterans are returning in drones, literally, back to the states, and we would really like to provide some outreach out there to get them some help, should they need it.

We would really like to look at technology and really

expand on our technology to really think outside-of-the-box and go outside of our Polycom or our videoconferencing systems, which that really goes into some of our challenges, you know, with the equipment. It gets dated. In some of our smaller communities, the buildings are so old and the confidentiality can be an issue, and sometimes with the T1 line, they are not confidential. You know, we can't -- you know, if we're sitting out in a clinic, in one of the external clinics and the only place to have a videoconferencing system is either in the emergency room or another room that is serving a dual purpose, perhaps as the dental clinic, as it is in Hoonah, you know, someone can easily, you know, just come through the door. You know, you've got a client sitting in there talking to the psychiatrist, and you've got a confidentiality breach right there. So we really are looking at ways to use technology into expanding that experience. Let's think outside-of-the-box, outside of the videoconferencing system, maybe moving forward into more of a point-to-point system.

We're piloting, right now, in our Juneau community, doing intakes and assessments with a -- we're contracted with an organization that's located in St. Louis, and we've got a point-to-point -- it's called Secure TeleHealth, where we have individuals that are coming into the Juneau clinic. They sit in front of a videoconferencing screen. They get a full

integrated behavioral health assessment, and the appointment, in general, lasts two hours, and it's exciting. It's a good experience for the client, and it's a good -- it really helps out with some of our capacity issues. We're finding that, in our larger areas in both Sitka and Juneau, we're having to maintain waiting lists for individuals that are seeking mental health and substance abuse services, which is not good. You know, we try to triage those individuals, to get the more urgent clients in as soon as we can, but you really don't want to have someone that is in need of mental health or substance abuse services, and they're ready. They've been brave. They've made that first phone call. They've sought out some help. We need to be able to respond to them.

So we're thinking about just really expanding the point-to-point system. We're told by the organization that we contract with, Secure TeleHealth, by the end of this year, they will have the technology in place to offer that same type of technology using iPads, you know, and I think that's something that we could really look at as we are starting to do our outreach with the veterans, for example. I think that, you know, if we can get additional support groups out to our veterans and to those that need substance abuse support groups, that might be one way to do that.

We also -- let me make sure I've covered everything. Oh, another area that we're really thinking about expanding is

we're talking to the same organization that is doing our assessments for us. They would like to pilot with us, providing after-hours support in our emergency room department here out in Mount Edgecumbe Hospital in Sitka and that is setting up a videoconference to their call center, which is open 24 hours a day, 7 days a week.

Let's say we have a client that is coming in, you know, after hours, we have limited staffing to provide that after-hours care to those individuals, but we would like to pilot to see if can get the behavioral health services available through teleconference. You know, it's something -- it's just one of the areas that we are going to be exploring.

And I think I agree with our other panel members regarding the barriers, you know, the barriers right now in the system. We talked about them. The T1 line, sometimes it will be all set up for a telebehavioral encounter, and something will go wrong with the T1 line, and it's not working that day. The Polycom is not working at all, and you've got to reschedule the client in for another visit because of some of those limitations in the lines themselves.

And I was going to ask Ed, is there something I missed?

MR. SUGAI: No. That's the key points that we have. I just wanted to emphasize one of the limiting factors that doesn't get as much gory detail is the fact that our limiting factor here is our network infrastructure and that is an issue

that should require management attention. We are very much onboard as far as the implementation of the new technologies at the end points. So thank you very much.

CHAIR HURLBURT: Thank you both very much. Why don't we move to the first Reactor Panel? We'll have until about 11 o'clock. And then if there are questions or comments from the Commission members, I think we could address either, the presentation we just heard. I mentioned Melissa Stone, Director of Division of Public Health and Chris Tarpley, who gets the award for coming the longest distance, coming from Oklahoma there, who Melissa has said very good things about previously. So we welcome you, Chris. I'll turn it over to you.

MS. STONE: Melissa Stone, Director of Behavioral Health. It's good to be here, and I appreciate Deb inviting us to participate unexpectedly. It, frankly, wasn't planned that Chris' coming to the state to talk with the behavioral health providers would coincide with the Health Care Commission when you're talking about telebehavioral health. So it's a great coincidence, and I'm really excited about the model in Oklahoma and what it potentially brings to behavioral health and beyond behavioral health to integrate systems and networks and not individual provider groups.

Just quickly and I'll turn it over to Chris, our interest in this came about -- the Substance and Mental Health Services

Administration, through the Center for Substance Abuse Treatment, provides technical assistance to states, and we asked for some technical assistance from them relative to substance abuse services in the state, and they hooked us up with a webinar with the state of Oklahoma with Chris' predecessor, Sean Couch, and that's how we really learned about what's going on in Oklahoma.

And I'm going to jump to the chase with his numbers and let you know that they're doing 70 behavioral health sessions annually, 70,000 -- sorry, 70,000 behavioral health sessions annually. He's the Administrator of the Network Server System, and I'll turn it over to him for that explanation. Thanks.

MR. TARPLEY: Thank you, Melody. I just want to be glad I decided to take the flight this afternoon instead of at 1 o'clock this morning, like I was almost about to do.

I want to start off by mentioning that I really liked the emphasis presented during Dr. Ferguson's presentation about Ontario's model, a network of networks. This allows the little silos of telehealth throughout the state to be able to be joined together, so that any one point of access at any location can be used for any kind of service, whether you're talking about telestroke or behavioral health or primary care, other kinds of telehealth.

For the technical side, this is actually really easy to

accomplish. It's through a process called Neighboring Gatekeepers. The gatekeepers are the devices that allow these various telehealth units, these sites to be able to talk to each other, and in the idea of a network-of-networks, you take these gatekeepers and let them talk to each other, and suddenly, you have discreet organizations being able to act as partners. And if you have multiple organizations, multiple populations, they'll all start to seem like they have the same kind of needs. Then a partnership and a collaboration is what's needed.

We are in the middle of starting to do that in Oklahoma. We have a telebehavioral health network from the Department of Mental Health that has expanded statewide for behavioral health, and we kind of have a network-of-networks in behavioral health of sorts. All of our various private providers network in with us and then we're taking our network-of-networks and networking it with other networks-of-networks with the colleges, the universities, the hospitals, and that's the collaboration we're starting to build, and in fact, modeling it after Georgia, which has already done this.

And one final point I'd like to make, especially, is that there is -- Melody mentioned that they are soon to be able to use iPads. This is something we are extremely excited about because, instead of having a large cart or room they set up for telehealth, right now, we have the ability to use software

instead of hardware that can be put on any computer, a laptop, a PC, anything and that can be taken anywhere, into a home, into another location, carried under your arm, and we can use that for behavioral health, any video-teleconferencing application, and we're really looking forward to being able to use that on the iPad ourselves coming up soon, supposedly this summer and the ability to combine that with locally developed applications over a mobile device, pulling in health records, store and forward capabilities, email, popping in, consultations on-the-spot during a session with other providers, and this also helps that integration of primary care and behavioral health, being able to just, you know, while you are in a mental health session, say here, let me go ahead and bring in this specialist in stroke in -- on a doctor site on Noah where you have co-occurrence, but you do have it, from what I understand. So that's the kind of situation where that network-of-networks is useful, and the technology, like an iPad, allows you to pop in seamlessly. That's about all I have to say for now, I think.

COMMISSIONER ERICKSON: Melissa, I wonder if you could share a little bit about your interest in the future of telebehavioral health, why you invited Chris here in the first place, and some of the potential applications, especially with more mobile technology and areas where you see it, and maybe just a little bit about the new little pot of money you got to

explore all of this?

MS. STONE: Sure. Thank you. Well, the real excitement about this model from Oklahoma and the application to Alaska is to go beyond an agency's own service system and connect different service systems, which has huge implications, of course, for specialty care, for cross-coverage, for 24-hour care, for workforce issues. It's not at all uncommon throughout our system to have absences due to turnover, workforce, et cetera, and this cross-system networking allows just a hugely expanded ability to provide access and seamless care with different levels of practitioners.

I'm excited about the potential within the Department to integrate behavioral health with OCS, Office of Children's Services, Division of Juvenile Justice with primary care, and then again greater private health care has the potential for, you know, a health aide going out with the personal computer to hook up with the patient with the clinician in a hub area with the primary care doctor in another whole area. That's basically what's happening in Oklahoma, and certainly, we know -- people have talked about the bandwidth issues we have, and I think we're also hearing that we're moving ahead in spite of the bandwidth issues, which I think is important. I think we can't -- you know, the little bit that I understand of this, we can't let that stop us from exploring where this is possible.

We thank the Legislature for a $90,000 increment in our FY13 budget, which gives us a start to explore this. I'm, you know, interested in a pilot. We've been talking about pilots here, and I would really like to see us, as soon as possible, put together a pilot with this technology. The costs are really -- up front costs, as I understand it relative to the server, and frankly, the pilot cost sounds like (indiscernible - voice lowered) infrastructure, so once you've got a pilot, you've got the majority of the costs established.

So how we proceed, I think, you know, we need to have discussions within the Department, but I'm very eager to move this forward, and I think it has just a huge potential for delivery of care.

COMMISSIONER KELLER: It's exciting, Melissa, really, really exciting, and I -- but what I want to know -- Chris, you made a statement that Neighboring Gatekeepers, which is Greek to me, is easy. Now easy -- and you said -- you talked about Georgia and that. Can you just talk a little bit more about the process of getting this in place? I would assume, like if you're going to merge the networks of OCS, for example, and SEARHC, you know, or SEARHC with AFHCAN or whatever, that, you know, you've got different visions; you've got different philosophies. So is part of that process getting these groups together? Is there an oversight over -- you know, I mean, talk to me about that a little bit.

MR. TARPLEY: Certainly. Well, I can speak primarily on the technical side of things. I'm an IT guy, who has gotten to expand his field over the past little while. In fact, on the technical side, it's literally a matter of minutes. I have one server that -- well, I manage five servers, but I would take one server, my external gatekeeper, and I would give it some information about the other gatekeeper that I want to neighbor it to, basically tell them to talk to each other, and they would do so. It's that simple.

The challenge, of course, comes, as you mentioned, on the administrative side. There has to, of course, be agreements between two organizations to start working together. There will, of course, be differences in cultures and visions and methods, but you know, that's what collaboration is all about. Work through it. Talk. Go from there. That's what we're starting to do.

COMMISSIONER BRANCO: So you're saying machine-to-machine is easier than people-to-people; let me get that right.

MR. TARPLEY: About 110% of the time, sir.

COMMISSIONER CAMPBELL: Melissa, on the up end about the technical skills of people who are going to be talking from, let's say, an ER with somebody with a psychotic break and there is no psychiatrist in the community or clinician, do you have that in place or whose duty is that to make sure this up channel stuff is -- and the service provider is going to be

there when this happens?

MS. STONE: We already have requirements in our system throughout the state for emergency services response. So this would, as people are saying with the medical component, allow a connection with different levels of practitioners via telehealth to assist with that assessment, and hopefully, prevent costs of unnecessary transport, and I think -- you're shaking your head -- that's one of the ways they're using the technology in Oklahoma is for emergency services. They're also using it with connection with courts, and I'm not sure of some of the other applications that you're using it for.

MR. TARPLEY: In fact, we are seeing extensive use of telehealth in Oklahoma for EODs in hospitals in order to decrease travel times for when you have, say, a psychotic break occur in a rural community, instead of having to drive them all the way to a crisis center to receive their initial assessment for a commitment.....

MS. STONE: They have roads.

MR. TARPLEY: That's true; we have roads. So you know, when I say drive, think fly, I guess, or Medivac. We're able to have that initial assessment done locally via video, so that there isn't that gap in timeframe. We've had consumers in Oklahoma that have taken the opportunity of that timeframe of a two or three hour drive/fly to calm down and that means that they don't get the assessment they need when they arrive

at the crisis center. We actually had somebody who was threatening to commit suicide calm down during that timeframe, during that ride, got turned away, and the next day, fulfilled his threat. That was the real impetus to create this program.

Right now, we have two clinicians -- I'm using the wrong term, I'm sure -- who are able to conduct those assessments, available in shifts 24 hours a day, seven days a week, and they do those assessments for the major hospitals in the state. So we always have a local ability to do crisis assessments. And we also have tele-court trainings, and you know, all sorts of other things for all the state agencies. We're always expanding.

CHAIR HURLBURT: One last question, Bob.

COMMISSIONER URATA: It sounds like you're saying that, from a technological point of view, one-size-fits-all, and if that's the case, I mean, there has got to be a glitch here and there, and I was just wondering if you could comment on some of the things that don't work very well with this, if that's true.

MR. TARPLEY: Oh, there are always complications. That's where you have people working through them. We've run into facilities that want to come onboard, but they just don't have the bandwidth to handle it. Bandwidth is absolutely critical for this, clearly. I was really impressed by hearing about how telehealth started in Alaska via store and forward,

essentially just email, because that's the bandwidth you had available. That's fascinating. That's an incredible application of telehealth. Honestly, we haven't started using store and forward in behavioral health because there hasn't been as much of a need for it. We've also, occasionally, run into a few cultural differences between organizations. In fact, I ran into a situation just this past month where I, unfortunately, made an assumption that those differences still existed when, in fact, they had mended over a year. And now I have a great working relationship with an organization that we didn't a year before. So those things are fluid. They change with time. They adapt. Technology continuously evolves, and you do what you can with what you have at the moment and look forward to future partnerships as they arise.

CHAIR HURLBURT: Thank you very much. We'll move on to the next section, which is our Rural Provider Perspective here, and if we could have Phil Hofstetter, Dr. Phil Hofstetter, who is the Director of Audiology with Norton Sound, and Dave Morgan, who is Revenue Director with SouthCentral -- and then on the phone, I believe, Sheila Stein, who is the Director of the Community Health Aide with Maniilaq. Sheila, are you on the phone?

(Pause)

CHAIR HURLBURT: Yeah. Let's just go ahead, and your charge -- we have until about 11:15 on this now -- would be to

share your perspectives on the exciting presentations that we've had today.

DR. HOFSTETTER: Yeah. So my name is Phil Hofstetter. As you said, I'm Director of Audiology in Nome at Norton Sound, and I've been there for about 14 years. And the first thing I could comment on is the reason I've been there for that long is store and forward telehealth. That's sort of our expertise. The first couple of years I was Norton Sound, I was ready to leave. It was very frustrating. Our referral process took so long, and when telemed came and we had an opportunity to use, we glommed on it, and it's definitely something that has retained me there over the years.

And as you saw with Drs. Kokesh and Ferguson, the publications that we have with our program are very, very -- it shows empirically that there was improvement within the system. So I'm very refreshed to talk to a panel that is sold on telehealth, as I am. So I'd like to sort of expand on what they had talked about today on the case creation side.

So, as audiologists, we create a case, and we send it to, for example, Dr. Kokesh down at ANMC. We also consult on cases that health aides create for us, and we also train health aides. So we have encompassed all capacities of the store and forward telehealth.

And some of the things we have noticed -- it's an outstanding system, and the communication that we have with

Dr. Kokesh's group is what -- that support, when a patient comes in and we are able to have his support behind a case, is really what creates that value and prevents the travel from someone leaving their village. So it's very powerful. It saves a ton of money. We present this to the board every year on the savings. So I would like to impose on the creation side -- let me explain to you a little bit on how much time it takes to create a case. So when they talk about reimbursement, that's something that I really think should be focused on.

When we create a case out in the village, it typically takes about 20 minutes on average and that's conservative, and the reason for that is we're using the medical devices on the cart. We're dealing with some of the delays, whether it's bandwidth or the use of the system and then we have to an incredible amount of case management.

So in order for Dr. Kokesh to consult on a case properly, I have to present that information properly. So I can't just send images and nothing, which, you know, happens sometimes. I have to look at what happened to that patient. I have to look up into the Meditech system. I have to look up when they were last seen, so that I can present that information, scan in my audiogram or upload it, use the images and the data that are available, so that Dr. Kokesh can respond appropriately and we can legitimately say that we saved travel on that

patient and that's counted as a follow-up.

So those kinds of things take a lot of time, and even though our patient numbers have relatively stayed the same -- we see about 3,000 patients a year -- our time has increased exponentially, and I do -- I wish I could show you a graph. We spend almost 400 hours just on telehealth a year now. That's conservative as well. So those kinds of things are demanding on our end, even though it's a wonderful system.

The second thing that I want to mention is that, originally when the telehealth came to be, it was funded from grants, from my understanding, and the medical devices on those carts were excellent. They were very well thought out. They're bomb-proof, essentially. There are some issues, obviously, but overall, it's been a very reliable system, which you cannot say out in the villages of many technology pieces.

So one problem we have come across is supporting those devices. A lot of them are becoming obsolete. And when you're not able to support those devices to be fiscally responsible -- that's the term I hear a lot now -- is that we have to look at maybe some inferior quality products that are out there and that's what's happening at both YK and Norton Sound is that we can't sustain some of these devices because, number one, we can't show that we're making this huge revenue, and number two is that those devices are expensive. And so I

would hate to see that go, and I think, to have a very smooth telehealth system, you have to have all those things in place, and they could be tentatives. You have to have good provider buy in on the creation side and on the consulting side. You have to have a good infrastructure, and you have to have IT support. All those things need to be in place. We've been extremely fortunate to have Stewart and John and myself to be able to support that with such a good network, and we do have a good administration and board that supports telemed within Norton Sound.

So some of those things are going to be the issues that are going to come down the table, and I worry that it will make -- it'll be -- in an environment that wants to pick and expand the telehealth system statewide, I think that any component of that it can make it as a point of failure. So that's something that I think has to be focused on in a credible amount. The data that they presented was phenomenal, but these are the things I see on the front line when we go to the villages.

CHAIR HURLBURT: Sheila? Did you come online, Sheila Stein? David?

COMMISSIONER MORGAN: I'm not really here representing SouthCentral Foundation. I, basically, do the numbers. I don't do billing. I have. I, basically, do cost reports for Medicaid and Medicare and special projects, like that, but in

a previous life as Operations Director for Eastern Aleutian Tribes, I was based in Sand Point and operated seven clinics for almost five years. I can tell you, before we actually got our carts and got active, we -- on Reeve Aleutian, which doesn't exist -- it's PenAir now -- I can remember countless times, at the $800 or $900 round-trip, we sent someone up here for a behavioral health evaluation or some other situations and then being told that we need to meet them because they're coming back through that.

So in my own mind listening to what I've heard today, I think, internally where you've seen massive expansion of telehealth, it's basically in an ACO environment, tribes. Though we don't call ourselves that, we are accountable organizations. We get dollars. We provide health care. Any efficiencies or cost reductions mean we can provide more by our mandate. We bill, basically, because that's our expansion money for new programs. Like I said, I'm talking for myself here watching all this.

I think you'll see that, internally to any developing any plan or attacking this is, we have to be diligent to make sure we have all the costs included. When you build a hospital -- my hospital friends will tell you -- you depreciate that hospital, and you make a sinking fund or allocate funds to replace that hospital, hopefully in equipment. I think you're right. Probably, hopefully, agencies and organizations have

done that with telehealth equipment. That depreciation and maintenance allocation is usually much shorter. FASBY (ph) and IRS give you, you know, three or five years, depending on the amount.

But I think, cutting to the chase is, I think, though we intuitively know that this does save money and may bring down reimbursement, we have to make sure that we can a) prove it, which means keeping information, keeping what is the effect of that activity, but also let's make sure we know all the costs and get those booked in. My intuitive sense, and from what I've seen this morning and what I know, especially in the behavioral health area, I think it does -- I think it could be -- it's been proven that it has in other locations, but Alaska needs to be very careful to make sure we can show that before we go and ask Jeff and insurance companies and Medicaid and Medicare to totally get onboard on this. I think it holds great promise, and I think we're at the first step.

It reminds me kind of like the relationship with VA three years ago. We may be getting close to that critical point where we can start breaking down some silos, but in this day and age, we have to be very careful to make sure that we don't make a false start.

My experience has been, especially in the behavioral health line -- I'm sure Emily can talk more on that -- it seems to be where the first breakthroughs were. I think, in

some of the specialty groups, especially in pediatrics and even the stroke, with this vast area and small volume and lack of specialists, it's almost shaped like a big anvil. You know, you have the low-hanging fruit and then you've got this stuff out here.

I'm sure we're going to make recommendations on it and make some good suggestions, but I guess it's the economist in me/accountant that I think we have to make sure that all the costs are included and not necessarily say get a grant. I've seen so many programs where you get a grant and then the grant is used up and you've got something that's over in the corner with a tarp over the top of it.

I guess that's pretty much my interpretation of it. I think we can move it along outside of the empaneled groupings, ACO groupings, if we change -- tweak the reimbursement a little bit so it's sort of approached at each end, depending upon the provider. And I especially like the idea of what they're doing with the ICU and the stroke. I think that offers some tremendous potential, too, but I'm still trying to get my mind around showing cost-effectiveness or a return on investment.

I'm not as quick off the mark as a lot of people. I have to think about things a little, but overall, I think, so far, it has been cost-effective of what we've done so far. I don't know. If anyone disagrees with me, I'm sure they'll jump up

and throw a dead cat or something into this, but I think that's pretty much just my interpretations. Like I said, if we really wanted to -- I can only talk from being out in the rural areas. While this was starting up and getting there, we did have cost-effectiveness for Eastern Aleutian Tribes. I haven't been that involved at SouthCentral. There are probably better qualified people, and some of them are sitting out there. But I think we need to pursue it and where it makes sense and improves quality -- I'll use Dr. Eby -- and lowers cost, real cost. We can't help, but we have to pursue it. So that's my five minutes' worth, whatever that's worth.

CHAIR HURLBURT: Thank you. I think we probably better keep moving on, and it looks like we're going to end up with our discussion time at the end, if we're going to go through with it.

Next is Paul Cartland, who is the State Health Information Technology Coordinator. Paul, we have until about 11:30 for you, if you can share your perspectives and maybe some of the things that you were going to say yesterday, all in the 12 minutes that we have.

COMMISSIONER ERICKSON: You should have seen Paul's face when he walked in and there were two of us sitting in this room last night.

MR. CARTLAND: You're not supposed to talk about how gleeful I was. Let's see. I'm trying to process what I was

supposed to say yesterday to see if I can roll any of that in here.

I've heard a couple things this morning that I think the Health Information Exchange Initiatives play well with. There are certainly several initiatives going on nationally as well as regionally that dovetail, I think, fairly well.

The Office of the National Coordinator has made a huge push -- this was in my presentation yesterday -- to urge all of the states, us in particular, to adopt direct secure messaging, which is nothing more than the store and forward that folks have been talking about all along, where, if I was a practitioner and I want to refer a patient to Dr. Hippler, I type an email, I attach whatever files, and those get sent to him, and he has the information that I need to give him, so that he can treat the patient.

There are any number of use cases where this is applicable, but it certainly plays well with this, in that its real intent is to bridge silos. You know, the ability of a Providence doc to refer to another Providence doc already exists within their electronic health record system. Where it breaks down is when the VA wants to refer me to Alaska Allergy or to -- and more importantly, get the information back. So the direct secure messaging solution that is being pushed is really intended to bridge those systems, so that's kind of the store and forward.

The second thing that goes with that, in my mind, is a provider directory. In order for this to be able to work, for direct secure messaging to be able to work, in order for a more robust scheduling system to work, you really need to know who are the players and how do I communicate with them, much like a Yellow Pages for communication other than telephone or fax.

And so along those lines, I'm participating and we're participating, along with Washington, California, Oregon, Idaho, New Mexico, Colorado, Arizona, Hawaii -- I think those are the states -- in a workgroup to develop a robust provider directory that also addresses some of the issues around, you know, what are the rules for me sharing this data across states lines because that's important. I need to know what I can share with a doc in California or what the doc in California can share with me, so that we make sure that we stay out of trouble. So we're participating in, and I think that is a part of this effort.

The thing that I heard loud and clear, actually a couple of things that I heard loud and clear this morning, certainly, the need to deal with the cost issue is important, but I'm not the cost guy. The part that I think I can work to help facilitate is it sounded like what we're missing -- one of the things we're missing is an agnostic centralized service that can facilitate the communication, the scheduling, and make

sure that the equipment to connect Dr. Hippler to Dr. Stinson -- I don't know that you guys talk -- works, you know.

So to that end, Dr. Ferguson and I were talking on the break, and he and I, I think, will try and put together a small group to come back with a proposal and say, you know, here's how we might make that work because I think that's one of the missing ingredients. Am I under my time?

CHAIR HURLBURT: You are. We actually have some time for any comments or questions from the Commission members now. Paul, thank you very much for being succinct.

MR. CARTLAND: Thank you.

CHAIR HURLBURT: Keith?

COMMISSIONER CAMPBELL: Did you establish a timetable for getting back with some recommendations or are you too preliminary yet?

MR. CARTLAND: We haven't figured out who is in the group yet, but Stewart's working on that while I'm talking.

The one thing I did say is that I don't want this to be a long, drawn out study. I think we need to move on this and so we'll come -- we'll get together soon and figure something out.

COMMISSIONER CAMPBELL: I, personally, would encourage that because we have a report due to the Legislature and the Governor early next year, and we'll be looking at those recommendations pretty quickly.

I'm reminded of ancient history, when we were talking about our audiologist friends from Nome. You, earlier, talked about the satellite that was here in the station and then got moved to India. That was an outgrowth of the old regional medical program, and I happened to be the hospital rep at that time with a whole bunch of doctors from up and down the West Coast.

And I was reminded of a trip, audiology-wise. They flew us out to -- soon after Norton Sound took over the hospital, they flew us out to White Mountain in a 206 and that was quite an experience for me personally, but the doctors -- we were in this little one-room clinic, and a lady came in with about a five-and-a-half-year old and said, we heard some doctor is here. Would you take a look at my son? And they said, why sure; what's wrong with him? And the mother said, his ears aren't running. Every other child in White Mountain, at that age, had nothing but super sore ears, and he stood out because he wasn't ill. Nobody else knew he wasn't ill, and it was just the most striking thing I had ever come across in my life. And then the opportunity to recommend moving the satellite for the first telehealth type thing in the state came along, and it's just been a progression all these years. So one thing builds on another, but I was just struck by that medical problem and how things have, I hope, changed in those areas, according to the use of technology.

CHAIR HURLBURT: Another fascinating Alaska medical story with lots of ramifications. Thank you. Paul -- you gave the caveat that he's not the dollar person. We're now going to have the payer perspective with Jeff Davis, who is the President and CEO of Premera Blue Cross Blue Shield of Alaska, and Kim Poppe-Smart, who is the Deputy Commissioner of the Department of Health and Social Services, who has responsibility for Medicaid and the Health Care Services Division. Thank you, Kim.

COMMISSIONER ERICKSON: I wonder if we have Debora just come up and sit, too, as a regulatory, sit together or not?

CHAIR HURLBURT: Sure.

COMMISSIONER ERICKSON: Debora, would you want to come sit with these folks, too, right now? These will be the last three panelists. We can get our payers and our regulators all together.

CHAIR HURLBURT: Debora Stovern is the Executive Administrator for the Alaska State Medical Board, relatively new to the job, and I was sharing with Debora the advantages that I've had of a somewhat peripatetic career with most of the time here in Alaska, but a lot of other places. My observation has consistently been the Alaska State Medical Board has functioned as the best board of any of the states that I've been in and continues to do, so we welcome you.

MS. STOVERN: Thank you.

CHAIR HURLBURT: Yeah. I'm not sure who -- Kim, are you going to start?

MS. POPPE-SMART: I'm not really the money person. We all know that's the Commissioner sitting back there, but I'll take a stab at it.

CHAIR HURLBURT: He told me not to let that secret out.

MS. POPPE-SMART: Yeah. It's tough being the money person, I'll tell you, because I've heard so many wonderful things today, a lot of exciting work going on, a lot of interesting things going on, a lot of incredibly interesting perspectives, not a lot of conversation going on though, except in these silos and before this Committee.

I'm not sure this is the right place, since this is not an operational body and not a decision-making body for what happens in operations, to have this well-rounded conversation, and what I think is really missing is abandonment of those silos, where we're talking about the infrastructure, we're talking about a payer and a provider in unison, but not collectively or we're talking about best practices out in the real world amongst providers, but not all of us together in the same room, and I truly think that's what's missing.

Providers will come to Medicaid and want to reimburse for their particular business model, not necessarily realizing the impacts to the entire Medicaid program for the decisions they've made within their own business structure to not access

full federal funds, in particular, but those are conversations that we need to have collectively so we can get to a model that meets Alaska's needs, as we've identified the needs, that meets reasonable business practice. So we are doing what Mr. Morgan is said is we're taking advantage of grant opportunities, for example, when it's appropriate, but we're also planning for those replacement costs and planning for the development of technology over the years. We are also being very, very thoughtful about other models that have worked in other places in the world, as you pointed out, Dr. Hurlburt. Other people are making this work for the same cost structure that we're currently working under, so isn't it working for us, what's happening?

I have been to a few meetings where I have heard about the number of encounters through telehealth for a Medicaid program, and I go back and look at my billing data. They don't match up at all. So people are leaving money on the table by not billing Medicaid when they can be. What's that about? So do we have barriers in our system? Let's talk about it. Is it just that the billing staff is turning over and nobody knows how to bill it? Let's get the technical assistance out there, so we can make this work. I don't think it's always about bringing more dollars to the table, but how can we be more effective and more efficient and more prudent and fiscally responsible with our public funds. That's a

start. Now you can fix it all.

COMMISSIONER DAVIS: Sure. I know one name that's on Stewart's list, and it's yours. So it's probably at the top of the list.

MS. POPPE-SMART: Is that a hit list?

COMMISSIONER DAVIS: No. No. That's the "who's going to solve this" list. This has been a fascinating conversation today, and Deb, note to self, when we do a Reactor Panel of all these bright people, I don't want to be last or next to last anymore because all the smart things have been said.

But for those of you have seen the movie *City Slickers*, and it's probably pretty much everyone in the room, you know, Curly's famous line is, "there's just one thing." And in our conversations, there is just one thing and that is that there is not just one thing. There are lots of things. There is personal health care. There is wellness. There are many of the things that we have talked about that all add up to this sojourn to try to find health for the citizens of Alaska and try to meet the vision that we laid out yesterday, which I find appropriate for this conversation.

So the point is that I think what we have talked about this morning with telehealth is definitely one of those many things, and I think Kim is exactly right that, you know, we've heard about all these exciting things happening in various pieces, but it's the question that, I think, Chris was

speaking to is how do you link that together because, if we don't figure that out, we're not going to reach our vision, but it seems like, if we can figure it out -- and I see -- I've heard nothing that would lead me to conclude that we can't, then we can advance towards our vision by doing -- all the good stuff has been taking already -- by improving quality and decreasing, and by improving access to the right care at the right time with the right provider for the right patient, you should be able to improve quality and to decrease costs, and if that hypothesis is, indeed, correct, then there should be a business model that works for that, and when I say business, I mean government and private business employers who are self-funded because that's -- all of the people that we serve are looking for that. They're saying we need value produced here.

We want to improve quality and decrease costs because this is a drain on our business model, and looking at health as a business strategy, again if this can be one way to make progress towards that -- and I do believe it can -- then we should pursue. And what's that pursuit look like? It looks like, I think, getting the right people together, which Paul and Stewart are already working on, and figuring out what that business model is because there is nothing that prevents us from finding a way to make it make financial sense. I mean, it probably does make financial sense. We just haven't

created an infrastructure around that, and we've been on the margins, the very far extreme margins of this for a long time, and it struck me that what we have is that people are willing to pay for the transaction, but there's nothing that pays for the up front costs. Well, we heard that this can be done on an iPad now. We could probably count the number of iPads in this room, and it would be a lot. So maybe we're getting closer to that, but maybe it just needs to be incorporated in the model, as Dave said, that it looks at the whole thing.

One last thought and then I'll go. So there are creative ways to do things, and Dr. Hurlburt was kind enough this morning to call my attention to some actually positive press that an insurer got. So we should probably write that down, and I'm just putting this out as one example. But our company has found a way -- in Washington, we have created what we're calling global outcomes contracting, which says, okay, providers, we're going to look at -- and the problem with applying it to Alaska is you've got to have big enough numbers for the numbers to work, but say you have a population that you're taking care of. We're not going to capitate you. We're not going to do any of that stuff, but we're going to look at what you spent last year. We're going to look at what we would anticipate, if you do nothing, you'll spend next year. And if you spend less than that because you've managed care, improved quality/decreased costs, we'll pay you part of

that difference. That's pretty cool. And guess what? Of the 12 or so clinics or groups that we've worked with, they've all achieved that. Imagine that. So follow the money; you can do that.

And just a local example with Providence and the eICU, they had the same challenge. They said, we're going to spend all this money. We're going to do all this. We're going to decrease length of stay in the ICU, which means we're going to decrease our revenue, but it's the right thing to do, so we're going to do it.

So Premera partner, what are we going to do about that? And we did basically the same methodology. We said, this is what we would anticipate. If we see something less than that, we'll figure out how to make that worth your while. So perhaps there are models that we could use in a comprehensive planning approach that would help to solve those reimbursement issues beyond just fee-for-service. Thank you.

MS. STOVERN: Well, we seldom get positive press, so thank you, Dr. Hurlburt, for that. I appreciate it very much.

The regulatory perspective -- I was going to also comment. We've heard so many wonderfully informative presentations today, so I don't have a whole lot to add. But the Medical Board, we all know our mandate, our sole mandate, is protection of the public. We do that through licensing, regulation, and discipline.

Telehealth must include both quality care, patient safety, and access, and we're a little less interested in the access issue than we are in the quality and safety issues, but obviously, the Board supports improved access as being part of those within the safety and quality issues. The Board position on telemedicine is driven by statute and regulation, and the Board position involves the licensing requirement, the physician rendering a diagnosis, reading or interpreting film samples or images, those types of things, must be licensed as an Alaskan physician because they are practicing with an Alaskan patient. So they're considered practicing medicine in the state of Alaska.

The only exception would be curbside opinions where it's an opinion offered as a courtesy to a colleague for no charge. We all know that; that's basic. The other two items are the unprofessional conduct laws regarding treatment, based solely on patient-supplied information received electronically and that's kind of a key. So the Board obviously supports telehealth, supports all of the wonderful examples of telehealth that we've heard today within those parameters. Obviously, things like a community health aide consulting with a regional center, Dr. Urata dealing with e-Health with Providence, eICU with Providence, Dr. Stinson consulting with an out of state specialist. Those things all fall within the current statutory environment.

Things that the Board discourages and are a clear violation of law are things -- and we deal with these on a regular basis. These inquiries are things like a guy getting on the Internet and filling out a questionnaire and getting a Viagra prescription, or just recently, the Board had made a determination on a program that was being proposed as part of an insurance program for employees of an organization that involved consulting via Skype, which is not a very secure system, on primary care issues in order to obtain prescriptions and that's a clear violation of Alaska law. So those are the things that the Board is concerned with.

The Board is comfortable, currently, with the statutes and regulations, as I just discussed, that they allow for and facilitate the kind of telehealth that we've been hearing about today, and we'll continue to assess and evaluate and make changes as necessary as technology improves.

I had a couple of responses to some of the things that we heard today. The licensing issue, I was very encouraged to hear, I think, it was Dr. Kokesh this morning who said that licensure was not an issue, which is a nice thing to hear. In the telehealth dialogue nationally, licensure is considered a barrier in a number of cases. So I'm glad, in Alaska, we're not seen that way. I mean, obviously, our obvious -- the basis of the licensing program, we all know, is to ensure the education, training, and competence of our practitioners, and

it's an important function, but we don't want to stand in the way of patient care.

So a couple of comments I had, I had a thought about the reimbursement issues. It seems, to me -- and I'm not that involved in it, but it seems, to me, that issue is similar to, in years past, the preventative care issues of reimbursement and that sorted itself out, and it seems like we're going along that same path and sorting that out as data comes back and we find that it's cost savings overall.

The other thought I had hearing about Oklahoma's advances, I think Oklahoma -- my understanding is they have a global green initiative, which encompasses so many things, not just telehealth, and I would sure like to see that happen in our state, and I know that's not the purview of this Commission, but it does encompass telehealth in a big way. Everything -- their initiative, I'm working with the Medical Board Exec in Oklahoma on a lot of their e-commerce that they're doing and trying to implement that for our Board here, but everything from telehealth to relieving real estate space from file cabinets by electronic records to the teleconferencing that we do at our board meetings and things like that. So those were just a couple of my comments about the things I heard this morning. Thank you.

CHAIR HURLBURT: Colonel Harrell?

COMMISSIONER HARRELL: So a question for you from a

regulatory perspective, so, as a DOD employee, obviously, I have a large organization that's (indiscernible - voice lowered) for me, so I'm licensed in the state of Colorado, but as long as I'm within the scope of my care, I can see patients here in the state of Alaska in that federal environment. What are the inhibitions, from your perspective, regarding medical licensure reciprocity? Give me the top two things that you say, got it, interest of safety. So assuming we can validate, you know, an appropriate medical school or whatever certification, we can do all that because we have electronic systems, (indiscernible - voice lowered). I can reach across the entire state and figure out where we're at. Assuming all of that is a given, what are the real prohibitions for the state of Alaska to develop reciprocity agreements across the board to facilitate telehealth?

MS. STOVERN: You're talking about reciprocity in the sense of using your out of state license to practice (indiscernible - simultaneous speaking)?

COMMISSIONER HARRELL: Right. So we have a relationship with a gentleman in Idaho who reads our sleep studies, but that's under the auspice of a federal agreement, not a state, but what prohibits the states, and specifically Alaska, from being able to move out and accomplish the same kinds of things? What are the barriers? And I know there are probably many. Give me the top two.

MS. STOVERN: I have the top two. The first one is the disparity between credentialing requirements amongst the states. There is a range of differences between the state licensing requirements. So we have set, by statute and regulation, as I mentioned earlier, you know, education, credentialing, training and credentialing, requirements to practice in our state, and it may be a higher level than another state. That's one.

COMMISSIONER HARRELL: So using number one -- I'm going to probe you a little bit. So using number one, Alaska has got its standard. What prohibits you from going to the State Medical Examiner Board in Montana and saying we'd like to be able to work out a relationship with you? These are our standards; what are yours? Well, we need to have this common standard, if we're going to be able to do that in the future. What stops that discussion?

MS. STOVERN: Well, we don't have a true reciprocity, but we do have a licensure by credentials option that already kind of acknowledges that and does exactly that.

COMMISSIONER HARRELL: So then it's a partial barrier?

MS. STOVERN: Yeah. Maybe. I don't think it's a barrier so much as it's sometimes seen as a challenge, I guess, to go through the licensing process, you know, time. There are a lot of different parts and pieces to the puzzle. You know, verifying med school, post-graduate, all the hospital

privileges, verifications, all those things tend to take time and tend to be a frustration to a practitioner who just wants to start working, and I think that's the biggest, I guess, complaint that I see is that timeframe.

And the second part is discipline. There are always bad actors out there. If we don't have a license over which we have jurisdiction, there is an extreme limit on what we can do to investigate and take action when a bad outcome occurs.

COMMISSIONER HARRELL: All right. So the solution might be, in that situation, that I, as a provider -- I don't know why I chose Montana, but anyway, I, as a provider in Montana, agree that I want to provide a service in the state of Alaska. Then as part of that agreement, I would have to concede that, if I am providing a function that serves the state of Alaska, I fall under their jurisdiction for disciplinary issues and that's not a big stumbling block for me because I go in, as the provider, understanding, if something happens in this state, I'm responsible for that state. If something happens back in my home state of Montana, I'm responsible for that state because there is agreement between the two, and I voluntarily entered that relationship. So I'm wondering about that being a significant barrier as well.

MS. STOVERN: It seems like it should be that simple; it's not. The problem is money, number one. We don't have licensing fees to now fund our discipline or our investigative

processes. If the licensing fee went to another state, the action would be taken on that other state license. I pick on taxes all the time, the Montana license in this case. It would -- since the action would fall within the jurisdiction of the Montana board because they have jurisdiction over the Montana license, they would have the responsibility for investigating a complaint, and they, number one, aren't going to prioritize that. They aren't going to come to Alaska to investigate. We might be able to come up with some kind of arrangement where our investigators did it, but you have a lot of those jurisdictional issues with our investigators being able to obtain information in order to facilitate their investigation.

COMMISSIONER BRANCO: Can I piggyback on that? So it's the question of a key to telehealth. Is it where the provider is and resides or where the patient is and resides that's at issue?

MS. STOVERN: The patient. Absolutely the patient.

COMMISSIONER STINSON: I was -- as you know, I was on the State Medical Board. Sometimes -- and this might sound impossible, but it's not -- when people applied for Alaska, they'd do such a thorough job, and years ago, Alaska did not, but now it is maybe the most stringent state, that people who are applying from other states, when they do the investigation, they find things that the state that the person

is coming from isn't even aware of and they report it back to that state medical board and then they might pursue investigating -- the other state might pursue investigating that. Meanwhile, they're being yelled at for not approving the Alaska state medical license, and it could be a year or more, and when I was on the board, we had things like that.

MS. STOVERN: And just real quickly, I can tell you that I've been with the board now nearly two years, and because there were so many of those kinds of complaints and frustrations with the timeframe, I started tracking our licensing processes. We can grant a license from the time an application is complete and all those parts and pieces are in place to the time that I grant approval of a temporary permit. Our shortest timeframe was one day, and it's usually ten days from that timeframe. So it's really not as long as it sounds like.

The main comment I want to make here is that the people that complain the loudest are the ones that have problems. They have license actions in other states. They've lost hospital privileges. They've got felony convictions, you know, things like that, and they're the ones that take the longest to review. They're the ones who aren't going to qualify for that temporary permit, that fast-track permit, and they're the ones that make the most noise. So I agree that there really isn't the problem that we hear discussed on the

national level, as least in our state.

COMMISSIONER HIPPLER: Thank you. Ultimately, I have a question for our regulator. A lot of what we have been hearing today about telehealth really, it gets efficiencies because, even though you're paying for two medical professionals and all their overhead, the front line clinician and the consultant, the cost savings of travel exceeds the extra overhead. That's a lot of the benefit of telehealth.

You gave as one of your examples of something that you would find in violation of various state regulations a consultation over Skype for prescriptions, but most people -- even in Alaska, most people don't have to pay huge travel expense to get to the end decision maker.

What I'm getting at is there is -- maybe we need some regulatory flexibility in order to take telehealth to the next level and bypass that front line clinician to get to the end decision maker that's required. I'm not sure how to get there, but I just thought I'd throw that out there.

MS. STOVERN: And I'll be just real brief. The issue is quality of care without that laying of the hands on that I think you said earlier and how much of that is necessary. The examples that I gave that are acceptable and appropriate and the things that we've been hearing about today involve an appropriate health care provider at both sides of the transaction, whether it's the community health aide or nursing

staff or what have you, but there is an appropriate health care provider with the patient, in this case, to facilitate the transaction.

COMMISSIONER HIPPLER: Okay, but that only saves money then when there is -- well, that only saves money under very specific circumstances, largely in rural Alaska. It doesn't apply to most instances in the rest of Alaska.

I understand that the licensure and regulatory requirements are designed to provide a reliable and high quality of care. I get it. That's a laudable goal, but every guild or set of rules involves increased costs as well as increased quality, and you know, we're at a point here where we're struggling with costs going up all the time, and one way to reduce costs is to accept the higher degree of risk.

MS. STOVERN: Well, given the Board's -- I understand what you're saying entirely and that's what the current position is right now is drawing that line, given the Board's mandate for public safety and that's where it's currently drawn, and obviously, the Board will continue to assess and evaluate and make changes as necessary.

COMMISSIONER MORGAN: One of the presentations, and I think it was the gentleman that came up, was talking about they had a limited number of behavioral health practitioners to do evaluations, and even though they had a road system and the patient was relatively close, they basically used

telehealth -- or I don't know. It wasn't store and forward. They actually could see each other and talk to help them do the evaluation because, if you wait a day, bad things could happen. And I believe it was the gentleman that was up here from -- yeah. Have I got it right? Is that right?

So there have been -- oh, he's back. There you are. I thought you got on a plane or something. But I mean, we could ask -- I mean, I'm just going to ask. Maybe I misheard, but you were doing that, which is the next level, in Oklahoma, and it wasn't vast distances. I mean, come up and just -- this is Alaska. Just come on up. Maybe I got it wrong, but correct me. Well, his point was, the only -- in his mind, the savings is the distance in that instead of, you know, sending them from Sand Point at $900 a round-trip, you do it through this and you still have the providers, but you had a program in Oklahoma where you were doing some evaluations in behavioral health, and it didn't sound like these were vast distances.

MR. TARPLEY: No. They were -- we might be talking about an hour travel. The town I live in, you can be rural in Oklahoma and be a half-hour away from Oklahoma City. It doesn't take long at all to get rural in Oklahoma, as I gather is the case in Alaska as well.

COMMISSIONER MORGAN: But the reason you did it, I think, was you had a limited number of practitioners.....

MR. TARPLEY: Yes. Yes.

COMMISSIONER MORGAN: .....and you needed to get the guy online?

MR. TARPLEY: Oh, yes.

COMMISSIONER MORGAN: The VA is very interested in this, too. You get the guy online to do an evaluation and to get him in for treatment or whatever and that's what was going on basically?

MR. TARPLEY: Oh, yes. The limited number of providers, especially specialty providers, is a significant situation we have in Oklahoma. There are only a bare handful of, for instance, clinical psychiatrists in the state, and they're in two cities, Oklahoma City and Tulsa, and that's it.

One of the benefits of telehealth, aside from this travel, is for folks to be able to get access to those providers that they wouldn't be able to otherwise.

When it comes to Skype, sure; we'd love to use a free solution like that, but it's not really a good solution. For instance, I can show someone how to hack into Skype in about ten minutes. It's not secure. It's not designed to be secure. That isn't part of the purpose it serves. You've got to have that in a health care environment, especially something as stigma-related as behavioral health.

Now one of the key things that we didn't really make clear earlier, from what I understand, is that -- and I may have the terminology wrong here; I think that we have this

right -- we do not use a consultation model, I think is what it's called. The -- in telehealth, where the consumer is, there is no clinician. The only -- we have a staff member at a clinic there, you know, waiting outside, you know, a secretary or office worker just there at some basic level of certification, just so they can come in and intervene if, you know, the consumer gets unruly, for instance, and that's it. Otherwise, they just go in, show for their appointment, go into the room, pop on the screen, have their session, and call it a day. So it's one-sided in terms of the provider.

COMMISSIONER MORGAN: It sounds like I was kind of close; is that right?

MR. TARPLEY: (Indiscernible - simultaneous speaking)

COMMISSIONER MORGAN: I wanted -- this is a shameless plug for Dr. Ferguson, but in my research to get ready, there is a study, which I'm going to give to our Director, called -- it's a little dated, but when you read it, it gives you a lot of insight on how all this got started and what they're doing -- the Alaska Federal Health Care Access Network Telemedicine Project back from 2004, but a lot of the people involved, especially Dr. Ferguson, are mentioned highly in there, but what's prophetic, in a way, is about one out of each of the three things that are barriers that they mentioned in this report are some of the things we heard today, and I think it would be -- if you're really interested in telemedicine, I

think this report, at least, it sort of -- you know, the opening chapter is "in the beginning," which gives you an idea of what's in here. And so I'm sorry to call you back up, but hey, you're here.

MR. TARPLEY: Not a problem. Haven't left yet. I called the airport and told them to hold the plane.

Just to clarify a little bit, some of that software we use I could go ahead and put it on that Dell laptop she's using right now. It's not a big system or anything like that. The software is actually freely downloadable. It's just the accounts that cost money, but it's a significantly less cost. Instead of anywhere from $3,000 to $20,000 for a unit, it costs about $3,000 for 25 accounts for the software.

CHAIR HURLBURT: Thank you, Chris. Thanks for coming back up. Are there any other comments or questions for this last panel? And then we'll move into our discussion. Representative Keller?

COMMISSIONER KELLER: If I could, just a statement. Chris, for me, you're the highlight of the day. Thank you, Melissa.

CHAIR HURLBURT: Thank you. Thank you, members of the panel. Deb, I'll turn it over to you, and we want to move into the phase where we talk about, reflect on, consider what we've heard the last couple of days and get some initial thoughts on how we can direct that toward our recommendations

for our next report. Wes?

COMMISSIONER KELLER: What's that they say about fools rush in? It occurs, to me, that Myra might have given us a direction yesterday when she talked about creating a crisis, you know. I mean, listening to Chris, what he said, we know -- I mean, I think we all saw today, clearly, that silos exist, and the technology reasons for them existing just are minimal, at least from what we have today. So why don't set a deadline for the Department of Health and Social Services? Paul is -- he's out of the room.

COMMISSIONER ERICKSON: No; he's there.

COMMISSIONER KELLER: Oh, he's hiding back there. No. To get some kind of a -- you know, something very specific, a Memorandum of Understanding. Create the crisis, you know. Create the room where we lock everybody and say we want something by such-and-such a time. I see an opportunity; I just wanted to throw it out there.

COMMISSIONER BRANCO: This is going to come out as kind of a strange circular story. Telemedicine is not a new concept, not by any measure. It goes back to the Wild West. It didn't involve telephones. It didn't involve computers. I'm sure the physicians in the room have had varying stages of this. My first exposure was 1978 in the Indian Ocean in which I spoke on a radio with a surgeon in California as I finished a traumatic amputation on a young man on a Navy ship, and it

was literally -- my side was, it's still bleeding; over. And the guy said, put a clamp on it; over. And I said, on what? Over. But the outcome was fantastic. The young man retained the use of his fingers.

Telemedicine, in my view, is all about our main theme for today, and it's access, even though we do need the business model to make it a reasonable endeavor for people to engage further in and to become more involved in making it happen, but it is the concept of -- I think telemedicine is the mother of invention where necessity used to be.

This is what we have to do to provide access throughout our state to make it achievable, and like you said, let's set a deadline to make this a reasonable function for all of Alaskans, whether they're in Wasilla or in Ketchikan or Barrow. I think we can do this and take this real -- one piece that Dr. Ferguson and I talked about was the fact that we have a surprising number of older folks in the state who readily accept the new technology, and we're kind of scratching our heads. The rest of the nation isn't like this. Those are the resister group. What we realized is these are the pioneers. These are the champions. These are the people who took bold steps into unknown territory and did what needed to be done. They created their own path. They're not afraid of new technology. So that's my view.

COMMISSIONER ENNIS: I think David talked about examining

some of the unknown costs or maybe the unrealized costs or the undefined costs. What I heard today was that, although we are expecting to realize great savings, particularly through travel and definitely more patient satisfaction, more expedient consultation and perhaps diagnosis, more treatment faster for our customers, our patients, that there isn't a clear way that the savings from the travel can be applied to some of those additional costs, and Phil addressed this, I think, most specifically, and the additional staff and professional time that might be involved in telemedicine, how we capture that, how we quantify that, and also the maintenance and reserve for the sophisticated equipment or maybe even the basic equipment that's involved. How is the reimbursement created, the increase in reimbursement created to address those costs? It may not be from the savings, say, from Medicaid travel and so I think that needs to be examined in detail.

COMMISSIONER HARRELL: So Emily, that was number one for me. I think I boiled the discussion into three major areas. One of them was a restructure of reimbursement schedules. Because of how telehealth/telemedicine is practiced, you've got to create incentive to be able to do that. It would be nice to think everybody would be altruistic, but the truth is it takes time, and time and effort then require some -- the reincentivized methodology out there to drive it.

Secondly, we talked about IT. I'm still not entirely convinced, based on what I'm hearing, that bandwidth is an issue in the state as opposed to actual structuring and whether or not the servers are geared that way, but there needs to be the IT component of this and really understanding what the limitations are to advance it.

And then lastly, it's such a big deal in terms of where this could all go. I think it would benefit the Commission to craft a position that says we've got to have some focus areas. I mean, we've clearly heard about behavioral health. And I certainly know, even just with my year here in the state, behavioral health and the ability to deliver that is phenomenally strained here.

And then in terms of rural care and primary care medicine, it would be very reasonable to identify several high utilizer, high cost disease sets that you would then focus on as the initial -- as we've talked about pilots because if you try to -- you've got to cone this down, I think, to be successful and make progress.

So I would recommend those three areas, and the last one being a clear focus of these are some areas we're going to definitely attack and move forward with, with some degree of vigor, and then let some other things begin to pile on as we generate success.

CHAIR HURLBURT: But where you comment on the

reimbursement methodologies being a need and opportunity, the other side of it -- and Kim just stepped out -- but it was Kim's comment that, from her perspective, she has money that's being left on the table now, and it may be on the provider side, and I would say certainly within the tribal health system. I would guess in your system, but maybe in the private system as well. It's new, and we may not have the expertise and may not have it far enough in front of our brains on a provider side. So that, along with the reimbursement, I think that the encouragement to not leave the money on the table that Kim talked about would be there. Jeff?

COMMISSIONER DAVIS: Thank you, Dr. Hurlburt. I'll just add on a little bit here, a couple of thoughts. One, I think it may be the mother of necessity. I'm not sure how this works, but I keep thinking about the Internet. I mean, who would have thought, ten years ago, that we would be using the Internet the way we use it? I don't think very many people had a clue of that, and it strikes me that this might be a similar situation by being able to figure out new ways for access.

On the savings side, you're right. I'm not the CFO. This probably is maybe why, but I do think like an economist sometimes, but I think, from the little bit I know about looking at risk factors and how they are correlated with

overall medical expense -- I'm looking at you, Dr. Stinson, because you know how this works. If you look at certain co-morbidities, the cost for taking care of someone just skyrockets, and behavioral health is top of the list. So you know, you take a situation where you've got access issues and timeliness issues, and you're able to figure out a way to get the right care to the right person at the right time. Is Mr. Streur here? That's his statement, right?

In behavioral health, it's harder to prove, but intuitively, you just can guess that that's going to have a significant impact on overall cost of care. So if we're able to use this to improve quality by increasing access to certain targeted things, you know, behavioral health, diabetes, heart failure perhaps, right -- these are the things that have been looked -- I think we've got the list, at least a start of the list. It's just, how we do we figure out how Premera members get access to what you've already built. You know, that's how -- and then, oh, by the way, pay you for it appropriately. And yeah. The model probably could be improved, but what if you now had more volume coming through? Then you've got the greater economies of scale. We've got all these little silos trying to pay for themselves. If we could figure out how to do it once instead of doing it three times or five times and we had an appropriate reimbursement uniform, you know, I think we can solve the cost problems, with the goal being producing

greater value, higher quality, lower costs that we all benefit from, regardless of payment source.

So I think there is a there there. We just need to get the right people -- encourage the right people to get together and figure out what it is.

COMMISSIONER ERICKSON: Can I ask a question first? Do you think we could attain that goal through identification and development of pilot projects, to collaborate around?

COMMISSIONER DAVIS: That's where my inclinations would be. Yeah, that you'd start with something that's -- I'd start with behavioral health, most likely. Knowing very little about anything, that's where I'd start because I think there are huge opportunities. A lot of the work has already been done, and we know there are shortages. And you don't have to.....

CHAIR HURLBURT: The biggest piece of the pie.

COMMISSIONER DAVIS: Yeah. Yeah. And it's -- I'm trying to remember the exact numbers, but there is something like, you know, seven -- you expect someone with behavioral health issues to consume seven times as much medical care as someone without.

COMMISSIONER KELLER: Just a clarification on that, Jeff. When you say behavioral health though, we're talking about getting rid of the silos. So I mean, in other words, you're saying behavioral health in the sense of incorporating them in

to the medical health information technology system, right?

COMMISSIONER DAVIS: So the silos I see are DOD is doing this. Medicaid is doing this. Private payers may be doing this. The tribal health system is doing this. Those are the silos, and I can't figure out -- that's what my question was earlier to Dr. Kokesh and to Dr. Ferguson was, how do make this applicable universally? So those are the first silos I see.

And I was just thinking to Colonel Harrell's point that, if you say we're going to figure out how do we put ourselves metaphorically in Barrow and figure out how we make this work, and let's just start with behavioral health, not to create an infrastructure that's specific to that, but because it sounds like a lot of the work is provider-specific, you know. Don't try to boil the ocean, but pick something that we believe has a high rate of potential return as a way to create a model that works and then start going down the line with other types of care because I think, first, you've got to wrap the behavioral health specialist in, right? You've got make it work. You've take what's happening today in the delivery system and figure out how to make it work more like what Chris was describing and that's going to be a different set of providers and a different set of entry points than if you're looking at diabetes, and it may be a different set of interventions. I mean, I know just enough to be really

dangerous with this, but that's what I was thinking, Wes.

COMMISSIONER KELLER: Just a real quick response. That really helped because, you know, I've got to explain for myself because this might help. I see the behavioral health system, in itself, potentially being a silo and that isn't a critical thing because, you know, of this mental health parity thing that came up ten years ago, you know, and there has been a stress point. But we heard from SEARHC. There was nothing in there, for example, that even came close to addressing a chronic disease in the context of the system that has been built and that's part of the magic I see that -- what Chris just pointed out -- there is no reason for that not to happen, and I think everybody wants it to happen. It's just a matter of, you know, talking about it and getting it on the table.

COMMISSIONER DAVIS: If I may, Mr. Chair, just a quick follow up to that? So that's probably, you know, like the "next," the "and" with it because we have heard -- this Commission has heard before that, if you can bring behavioral health into primary care as part of that, then you can have that impact. Again looking at the data saying depression is correlated with seven times as much use of other services, so that person sitting in Dr. Urata's office needs access but can't get access, and now through this, can get access, well, just a minute. Let's dial up -- you know, now you've got somebody on. He stays in the room or leaves the room. That

happens. Now you've linked those two in a way that's not possible today. I'm just making it up, but it seems like that should be possible.

COMMISSIONER STINSON: There are certain medical specialties that are, I think, more suited actually for telehealth. Radiology lead the way because you can send pictures anywhere, and now typically, there are people who take call for a radiology department clear across the country, take call for the Alaska radiology departments at night. I think behavioral health is one of those specialties.

You have the different silos that all have expertise. It's amazing listening to tribal health/DOD. If there was ever any way to get these folks together, my gosh, it would be a great -- you could get a great system.

Behavioral health, I think, would be a natural for this. The one thing about when you're going to do a study though, you've got to know what you're starting from. You have to collect some data before you start a study. Then you have to collect data and have objective, measurable goals that you're looking for because, at the end of some kind of pilot study, particularly with behavioral health -- because a lot of these people, they're depressed now; they're going to be depressed for the rest of their lives, some of them. What kind of data are you going to be looking for because, if you want to make an impact, make sure that you are doing something more than

expenditure, doing something more than less travel, doing something more if you want to get into quality.

So the only other caveat I was going -- I agree you need to cone down, absolutely. You can't do this for everything, but make sure you know what data you're going to be looking for that's agreed upon, that's measurable. So at the end, you don't say, we don't know.

COMMISSIONER MORGAN: I've sat in on some tribal business office meetings where they've done training on how the bill providers are payers for telehealth. Medicaid is kind of interesting. If you look at the back of each manual for that service or group of services, like whether it's behavioral health or whatever, in the back, all of them have a little section on telehealth, and it tells you exactly how to bill.

What I find funny -- well, it's not funny. It's kind of funny, like a train wreck funny. Basically, the bill in the Medicaid system is you take that ICD-9 number or the billing number and add two modifiers, so they can just tell it's telehealth. I think each payer is slightly different, but our business office trainers -- it just seems like it's continual because sometimes people approach things because, oh no, it's telehealth; I don't know how to do that, but all you have to do is go to the back of each of the manuals, which you could print off the system for Medicaid anyway and Blue Cross, and it'll give you the little two-pager on what they'll pay for

and how to bill for it, but it's just very bizarre sometimes, as the Deputy Commissioner was saying, of just getting people to pull it, look at it, and do it. I know travel -- and we have -- Gwen, who is in the audience, has worked on some of this. It just seems, because of turnover and just the subject matter, it becomes very -- you know, you just keep doing it, doing it, doing, but getting better and better and better at it, but it takes years to get it ingrained into the system, but it's doable, I think. I agree.

COMMISSIONER HARRELL: Just a follow-up to clarify in terms of the coning down piece, although we're accentuating behavioral medicine, I think it would be appropriate to also add, when you talk about pilots -- some finite number. Behavioral medicine may lead the way, but you probably also would be -- we would be well to focus on a couple of diagnoses or specialties where some more technical information has to change hands in terms of proof of concept because behavioral medicine lends itself to consultative services, but there is impact to be made in those diagnoses or specialties that require some data transfer, other than radiology. So as we look at the number of pilots, I think we should, at least, consider a couple or more that require some significant technical interface to be able to prove things.

COMMISSIONER STINSON: And that's a lot easier to measure, like diabetes, which is a big costly medical problem,

and yet, you can follow A1c. You can follow different things to document improvement, or at least, what is now considered to be improvement.

COMMISSIONER ERICKSON: You don't get to watch over your shoulder. I'm typing the main points about what each person is saying, but it's all coming together in my mind and some major themes, and some of our members have done a real good job of capturing those major themes, too. So we can kind of synthesize it at the end of the conversation, I think.

CHAIR HURLBURT: So we're.....

COMMISSIONER ERICKSON: We're good. We're good. That was a long answer to okay.

(Pause)

CHAIR HURLBURT: Do you want to go back to the top of your list and look down that for everybody?

COMMISSIONER ERICKSON: Well, I don't know that, but I think it's okay. We can go back and capture these later from future drafts. We didn't say much in the way of just general findings, although I think the main point that I'm hearing is that this is important and we need to pursue it as a mechanism for improving access and improving quality of care, and the emphasis on the importance of collaboration between providers and payers and breaking down silos between different sectors.

I just wanted to remind the group, at least those of you who are with us for our learning sessions on patient-centered

medical home -- and we actually captured this in our recommendations related to patient-centered medical home.

For those of you who weren't with us, we studied three different initiatives from down south that had demonstrated outcomes that were positive, both in terms of saving money and improving clinical outcomes, quality of care, but we pulled learnings about what we identified as the attributes of each of these that were common, each of these successful initiatives that were common to each other, and one of those things that was common to each of those was that there was a collaboration around these initiatives between payers and providers. Every single one of them had a collaborative relationship up front in designing the program from the very beginning between the providers and the payers. In one case, it was public insurance program, Medicaid. In another case, it was a Blue Cross program in Michigan.

But you all have captured that as an important aspect of moving forward with any kind of improvement work in this past recommendation, and maybe we, at some point, need to pull that out. If we're making recommendations about additional pilots now in telemedicine, beyond patient-centered medical homes, this is important to get these folks. As Kim was saying, it's interesting for the Commission to learn about it and to make recommendations about it, but we can't do anything about it. We're making advice on policy. The folks who can actually do

it, we need to get Jeff and Kim sitting down with Colonel Harrell and Dr. Urata and Dr. Stinson in the same room together actually planning something that they can implement.

So the collaborative approach to pilot programs is probably one of the first recommendations. Addressing the IT issue and gratefully accepting the offer I think we heard earlier from Stewart and Paul to put a group together to see what they can come up with for a strategy or a proposal for addressing the issue of having some sort of common IT platform or network -- I'm not enough of an IT person, but Chris is going, yeah, you're getting there, right? Whatever. You know. So we'll wordsmith that and get that captured.

As far as the reimbursement mechanisms, that's something that we'll identify as an issue, but that we would imagine would be addressed through the pilot programs in the collaboration between the providers and the payers and that some aspect of that will include perhaps making recommendations. And as we move through the year, we might refine this a little bit, if we can understand a little better what the -- problem with Medicaid, for example, as Dave is suggesting, it might be just be better training and guidance for the coders and the billing staff or what the issues are. We're probably not going to get -- this group isn't going to get into the level of detail in making recommendations to Medicaid about how billing should be improved for Medicaid,

but it might be a learning for a little more general recommendation that the group would make.

COMMISSIONER MORGAN: I don't think it's just tribal. I think -- as the Deputy Commissioner was saying, I think, whether it's a single provider or a specialty group or tribal -- all of them -- I think there is a lot of misunderstandings, and I'm probably -- I haven't been involved in billing for several years. So I've probably got it wrong, too, sort of, but I think, generally, there are problems with the training, and I don't think it's that big of a deal to do other than just doing it. It's more of, hey, maybe you need to do some more training, not tell anybody they have to do anymore training. And I agree. We're not operational, but there is nothing -- we talk about a lot of stuff, and we make some recommendations, and I don't think we've ever stepped over the line through this, you know.

COMMISSIONER ENNIS: As a provider that does bill Medicaid, I would like to say that, over the years, it has been increasingly -- it has become increasingly more burdensome and has required many additional staff for our organization to bill accurately and thoroughly and avoid the risk of billing and error because that can come with great penalty and payback, extrapolated payback to an agency. So I'm not saying that that is an explanation for some smaller organizations, perhaps, or even a larger organization not

billing or leaving something on the table, but if you don't have all your T's crossed, I's dotted, your signatures in place, all your backup documentation, there can be great risk at billing. So you know, things have changed dramatically in the last decade with billing Medicaid.

COMMISSIONER ERICKSON: I have one question for the group. I have these three major issues, the technology piece, the reimbursement piece, and then a collaborative approach to a couple of real specific pilots to help with answering all of these questions and figuring out to make it work in the future.

One of the things that Dr. Ferguson had mentioned and Dr. Kokesh at the end of their presentation, their suggestion for next steps was the need for a statewide vision. I guess that's the one thing that I'm wondering about is if we need some sort of umbrella for all of this. Yes?

COMMISSIONER DAVIS: So I guess we should ask Dr. Ferguson and Paul what they were thinking, but I wasn't -- I may have been wrong. Maybe it was just wishful thinking on my part. I wasn't hearing that they're going to get together and think about technology, but that they were going to get a group together to think about this as, you know, how do you make -- how do you create a business plan -- I keep using that terminology -- that makes this work from all of those perspectives, and technology would be part of that.

COMMISSIONER ERICKSON: Thank you for that clarification. Paul and Stewart are vigorously nodding their heads. Well, at least, Paul is vigorously nodding his head, and Stewart is going yeah.

COMMISSIONER DAVIS: And out of that, Deb, I think you get a vision.

COMMISSIONER ERICKSON: Thank you for the clarification.

COMMISSIONER KELLER: Just a comment. This isn't really a vision, I don't think, but the concept of 24/7 access, you know, to your medical system that they've presented in Ontario, that captured me, and I was wondering if -- you know, hey, I wonder if we couldn't have something like that, to hold that up as a possible goal/vision, whatever.

COMMISSIONER DAVIS: So speaking of Ontario and Oklahoma and Georgia, we heard them all mentioned as -- well, Ontario and Georgia as places where a lot of progress has been made. I don't know if there is a way we can know more about what they've done or if the group that's being pulled together will incorporate that as part of the work, but anyway, I don't think we need to start over.

COMMISSIONER ERICKSON: Please use the mic.

DR. FERGUSON: So you know, I have lots of opportunities to travel as part of my job with the telehealth as the President, and I see these other places. And you heard from the man from Oklahoma, and it's really nice when we get those

opportunities. And you know, I've been creating a list of things I'm going to talk to Paul about, and right here, it says visit Ontario. And I think there is nothing like getting out and going to a couple key sites that have, you know, lived and breathed this and gone through the trials and tribulations in really looking at how they did it. You can't do that over a phone call. I think you have to spend a couple days and talk to the folks and so I was going to suggest to Paul, and maybe we figure out who a few other key people are, that we'll go look at -- you know, I think Oklahoma definitely should be there, but definitely Ontario and go spend a few days.

And I'll just tell you I'm good friends with Ed Brown who runs it. He actually is very enamored with what we've done with store and forward, and he pitched the idea to me when I saw him in Michigan last month that, if we would give him our store and forward solution, he would give us his videoconferencing scheduling solution. So I'm all for, you know, quid pro quo. So these are the kinds of things -- we may actually see that this could take off and accelerate pretty quickly with a couple key visits. So I'm totally onboard.

COMMISSIONER HURLBURT: Anything else? Deb?

COMMISSIONER ERICKSON: I think that we have pretty much captured everybody's thoughts here around the table. I'm seeing lots of nodding heads. Unless there are any final

thoughts? I'm getting a thumbs-up. So should we just move into wrap-up?

CHAIR HURLBURT: Yeah. Any comments on process for this meeting for suggestions? The next meeting is going to be in August, end-of-life issues. I think it will be an interesting meeting. We spend 1% to 2% of our gross domestic product on health care at the end-of-life, much of it futilely. Some of it miraculously. We'll have a broad array of perspectives on what we do here. I think it should be an interesting meeting. You have the book that Dr. Byock wrote that you have to read in preparation for the reading. It goes pretty quickly, for those who haven't read it. How about this meeting, any comments on process? Yeah?

COMMISSIONER DAVIS: So I'd be interesting in Colonel Harrell's thoughts on this. I think was, perhaps, well, one of our top three meetings for sure, and I don't know if it was the subject matter, an exciting subject matter, and I think that's part of it, but we brought the right people, a variety of perspectives, and enough time to really let it sink in. So I think that was good. I think we're probably just getting better at this, and who knows, maybe it's the new members of the Commission who bring a superior level of process to it. I don't know, but those are the things I'm thinking about in terms of this was really good, I thought. And the evidence of that is how quickly we were able to come to agreement on what

we heard.

CHAIR HURLBURT: Other comments?

COMMISSIONER ERICKSON: Well, just a few things on logistics to wrap-up. For our meeting in August, we'll be at Providence and pretty much the same format, except we're going to have the first day dedicated. So I think one of the things we were learning is allowing more time for the group to process and reflect together. And so our first full day will be dedicated to that end-of-life conversation. And then we'll have time in the second day for our half-day to bring in some of the work that we've done in these two earlier meetings and make some decisions about findings and recommendations from those.

And I expect to be able to get the notebooks out to you in advance again. We didn't have much in the way of materials that wasn't presentations for this, and we were getting those as early as this morning still. But for our next meeting, I already have materials for notebooks coming together. So in addition to your reading, at least a week if not ten days or so in advance, you'll have a pre-meeting notebook again. But that's about it for logistical details. Yes, Jeff?

COMMISSIONER DAVIS: I don't know what's gotten into me today. So logistics, where at Providence? That's a big place. Do we know where exactly?

COMMISSIONER ERICKSON: We have the West Auditorium.

It'll be on the.....

COMMISSIONER DAVIS: The West Auditorium?

CHAIR HURLBURT: Right down (indiscernible - away from mic).....

COMMISSIONER ERICKSON: In the basement.

COMMISSIONER DAVIS: Great. Thank you. And then the second I will just say is another comment about this meeting. I really liked, to the extent we can, having the presentations with the format -- I don't know if it was a similar physical set up, but to be able to look at the presenter, but yet have the audience be able to see what's the on the screen really helps for me. I don't want my back to the presenter. So it works, and I can take notes on it. So thank you.

COMMISSIONER ERICKSON: Yeah. I actually am glad you mentioned that because I was thinking about that today, all day, watching you all going like this, even though you had the presentation in hard copy before you. So I would hate for Dr. Hurlburt and I to sit with our backs to the audience, but that was the one thing I was thinking we might just need to do, at least using this room in the future.

COMMISSIONER DAVIS: (Indiscernible - away from mic)

COMMISSIONER ERICKSON: Right. Any other suggestions for improvement at future meetings? No. I think we're ready to gavel out, Mr. Chair.

CHAIR HURLBURT: We're adjourned. Thank you all very

much again. Thank you.

12:37:41

(Off record)

END OF PROCEEDINGS